



Private Health Insurance And Public Health Goals In India

Report on a National Seminar

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INTRODUCTION

In anticipation of the passage of the Insurance Regulatory and Development Authority Act 1999, the Government of India (GOI) held a seminar for senior policy makers on health insurance. The objectives of the seminar, which was held on November 16-17, 1999, were to: (a) understand the potential risks and benefits of private health insurance; and (b) identify what the Government of India should do to ensure that social objectives are met with the liberalization of health insurance. The papers published in this volume highlight some of the key issues raised at the seminar, which should be of interest to those concerned with the future directions of India's health sector.

The meeting was attended by over 30 key policy makers and stakeholders, including representatives from the private sector (insurance companies, private care providers), academicians, senior public officials (from the office of the Prime Minister, Ministry of Health, Department of Insurance), and non-government organizations.

IN THE COURSE OF A LIVELY DEBATE, THE FOLLOWING MAJOR THEMES WERE ADDRESSED

Implications of current experiences in health insurance.

- Perspectives from the private sector financier.
- International experience with private health insurance.
- Prospects for health insurance in the informal sector.
- Regulation of health insurance in India.

This publication includes a selection of the presentations made at the conference. It begins with a paper by Charu Garg, which outlines the current situation of health insurance in India, describing the theoretical and practical aspects of the regulatory challenges that must be dealt with. Ajay Mahal's paper describes the legal tools currently available to regulate health insurance, the type of system needed to regulate health insurance effectively, and the large gap between the two. He further examines how liberalization of health insurance may effect the health markets in India. In Alejandro Ferreiro's paper, the international experience is used to argue that preventive regulation is more effective when a system is introduced, rather than waiting for the system to be in operation and then responding. The final paper is a summary of the workshop conclusions, which also offers some of steps for the future.

MAIN FINDINGS

As the GOI is moving forward with liberalization of the private insurance market, it will want to ensure that the outcome will offer value for money for the direct beneficiaries (which is estimated to include the five percent of the most wealthy Indians), and that it does not have an adverse impact on the poor. The proposed approach is to support voluntary insurance, rather than expanding

existing social insurance schemes. As a fee-for-service approach to payment of health providers is likely to emerge, along with the risk of cost escalation, the GOI would look for ways to encourage managed care models.

The likely impact on the poor is not clear. They could benefit from expansion of quality in the private sector, if the introduction of evidence-based medicine – that would be demanded by international health insurance companies – trickles down to other providers that are used more frequently by the poor. Alternatively, the gap between access in quality may increase, and there also remains a risk of subsidizing the wealthy. To deal with these issues, the following recommendations were made:

PRO-POOR RECOMMENDATIONS

- Reduce the public subsidy to the wealthy by charging full cost recovery to the insured who use private insurance, finance the regulatory agency through premiums (e.g. a 0.5 percent levy on premiums) and reduce or eliminate tax incentives for private insurance, particularly indemnity based insurance.
- Define a minimum package of services covered that include preventive, maternity, and catastrophic cases, in order to prevent such cases from being dumped back on the public sector.
- Encourage informal community financing schemes, e.g. managed care schemes through NGOs with less regulation and lower capital deposit requirements, and assess other financing options for the poor.

HEALTH SYSTEMS RECOMMENDATIONS

- Establish a specialized regulatory agency for health insurance which would define benefits packages, ensure transparency and comparability of packages, define treatment protocols, ensure guaranteed renewal of policies, reduce ability to deny coverage on the basis of pre-existing conditions, establish conflict resolution mechanisms, promote community financing, and monitor the performance of different schemes.
- Develop quality assurance procedures in health care.

IMPLICATIONS OF CURRENT EXPERIENCES OF HEALTH INSURANCE IN INDIA

INTRODUCTION

A large population (almost touching a billion), challenges of infectious and communicable diseases on one hand and life style diseases like cancer, AIDS, and coronary diseases on the other hand, and improving medical technology are some of the factors which contribute to increased costs of financing health care in India. It has been estimated that India spends 5 percent of the GDP on health care.¹ Of this more than three-quarters are financed by the private sector, which is mostly out-of-pocket. This large out-of-pocket expenditure on health care exists even though the role of the government in financing and providing almost free health care has been emphasized since the time of independence. Most people prefer the private sector for health care, presumably because they perceive quality to be better there and because of the failure of the public sector to respond to client needs (non-availability of functionaries, shortages of drugs consumables etc.). This leaves little option for both the rich and the poor but to seek private care.

The use of public services is determined not only by the quality of services, but also by the cost to the consumers. Reliance on private sector has increased as the gap between the average total expenditure on private and public facilities for inpatient treatment has decreased from 5 times in 1993-94 to 2 times in 1995-96 (Table 1). Further, the average expenditure per hospitalization episode at current prices has increased three times between 1993-94 and 1995-96 and four times between 1986-87 and 1995-96 for both rural and urban areas. Even at constant prices, an increase of 60 to 70 percent is evidenced in average expenditure per hospitalised treatment (Table 1). With the large majority of people living in the rural areas and about one-third of the population living below the poverty line, the question arises if individuals should pool their resources to cover uncertain costly events, which would otherwise be difficult for individuals to afford at the time of need.

TABLE 1

UTILISATION OF HEALTH SERVICES AND AVERAGE EXPENDITURE INCURRED FOR TREATMENT AS OUTPATIENT AND INPATIENT						
	1986-87		1993-94		1995-96	
	Rural	Urban	Rural	Urban	Rural	Urban
% of ailing persons not treated	18	11	12	8	17	9
% treated as Outpatient(OP)						
Public	26	28	42	34	19	20
Private	74	72	58	66	81	80
% treated as inpatients (IP)						
Public	60	60	61	60	44	43
Private	40	40	39	40	56	57
Average payment for OP treatment/episode (Rs.) (At current prices)						
Public	73	74	51	65	129	166
Private	78	81	123	141	186	200
All	76	79	93	115	176	194
Average Payment for OP treatment/episode (Rs.) (at constant 86-87 prices)						
Public	73	74	27	35	48	64
Private	78	81	65	75	74	81
All	76	79	49	61	69	78

¹ World Bank (1995) estimates (using 42nd round data of NSSO for 1986-87) 6 percent of GDP is being spent on health care. Using NCAER data for 1993-94, it is estimated that 5 percent of GDP is spent on health care (Garg 1998, 1999)

	1986-87		1993-94		1995-96	
	Rural	Urban	Rural	Urban	Rural	Urban
Average Total Expenditure for IP treatment /episode (Rs.) (at current prices)						
Public	722	653	559	452	2080	2195
Private	1156	1570	1876	2336	4300	5344
All	886	1007	1076	1210	3202	3921
Average Total Expenditure for IP treatment/episode (Rs.) (at constant 86-87 prices)						
Public	722	653	297	240	912	963
Private	1156	1570	998	1243	1886	2344
All	886	1007	572	644	1404	1720

Source: ○ For 1986-87 data: NSSO (1992)

○ For 1993-94: Garg (1998) Compiled from the tables in Shariff et. al. (1998)

○ GOI (1998)

Note: ○ Data for 1993-94 relates to the survey by NCAER and for 1986-87 and 1995-96 data relates to a survey by NSSO in their 42nd and 52nd round.

○ Consumer Price Index was used to convert the data from current to constant prices.

Health expenditures are known to follow a skewed distribution where expenditures are zero or very small for most people and large for very few people. Pooling is considered a way of realising social justice, because it is based on solidarity and cooperation between the well and ill, the rich and the poor. Pooling helps to avoid large financial risks, as well as help people gain access to health care that would otherwise be unaffordable. Thus, health insurance provides financial protection against the high cost of medical treatment and unpredictable health events.

It is presumed that the larger the number of people utilizing the health services of the private sector through health insurance, the less will be the burden on government resources to finance secondary and tertiary care. It is also argued that private insurance will be able to provide coverage to those who are ineligible for public insurance, or for those who want supplemental coverage not covered by public insurance programs. It is important to take into consideration the numerous diseases and a large population that will not be covered under private insurance because of the market failures associated with the private insurance system.

In the light of the above, the major objective of this study is to analyze the existing health insurance market in India to determine the critical issues/ risks and to identify the opportunities and constraints to bring about changes. This study also aims to identify the options for a more equitable health financing system, particularly for the poor. Interventions to guide changes in the current health insurance market in India are also suggested.

The study is divided into four sections. The introduction above outlines the need for studying the health insurance

markets in the Indian context. Section 2 discusses each of the formal and informal insurance markets in terms of the types of beneficiaries, level of coverage, types of benefits, premiums charged, provider payments and administrative costs. Section 3 discusses the risks associated with health insurance like moral hazards, adverse selection, skimming, supplier induced demand, high costs and low quality of care, and consumer redress mechanisms in the context of the health insurance products and the private health insurance market. In Section 4, various options for risk pooling are analysed. The final section has policy options for bringing changes to the health insurance market in India.

EXISTING HEALTH INSURANCE MARKETS IN INDIA

The health insurance market in India is generally very limited. The various schemes can be categorized into four broad groups: i) Mandatory health insurance schemes, ii) Voluntary health insurance schemes iii) Employer-based schemes and iv) Insurance offered by the NGO sector. The four schemes together are estimated to cover roughly about 10 percent of India's population.

Mandatory health insurance schemes

These are the Employees State Insurance Scheme (ESIS) for certain low-income employees of the organized industrial sector and the Central Government Health Scheme (CGHS) mainly for the central government employees. Both these schemes are principally financed by the contributions of beneficiaries and their employers and from taxes. The former receives some contribution from state governments whereas the latter is mainly financed from central government revenues. Under both

the schemes, the beneficiaries (which cover the family members also) are provided a wide gamut of services like preventive, promotive and curative care under various systems of medicine through the government-managed dispensaries and hospitals. In addition, ESIS also provides cash benefits. ESIS covered 35.4 million beneficiaries in 1998 and CGHS covered only 4.4 million beneficiaries in 1996. Providers mainly work on salaries and hospitals work under global budgets. Details of the schemes are given in Appendices 1 and 2.

Private (Voluntary) Health Insurance

Voluntary health insurance schemes for individuals and corporations are available mainly through the General Insurance Corporation (GIC) of India and its four subsidiaries - a government owned monopoly. These schemes are financed from household and corporate funds. GIC offers MEDICLAIM (MC) policy for groups and individuals and the JAN AROGYA BIMA scheme to individuals and families, mainly, to cover poor people. These policies have had only limited success in India covering only 1.7 million people in 1996. These are annual policies covering mainly hospitalised treatment. There are exclusions and pre-existing disease clauses. Further, the schemes are of indemnity type, which makes it unattractive for many. Providers have to be paid by the insured, who are in turn reimbursed by the insurer. Some of the innovations include no-claim bonuses, group discounts, tax exemptions, and no in-limits within the sum insured for. Premiums are risk rated according to age. Further, other schemes like overseas medical insurance, old age medical insurance and personal accident insurance also exist. Some of the details of the schemes are given in Appendix 3.

Employer Based Insurance

Health insurance is offered both by public and private sector companies through their own employer-managed facilities by way of lump sum payments, reimbursement of employees' health expenditure or covering them under the group health insurance policy with one of the subsidiaries of GIC. Workers buy health insurance through their employers, taking insurance in lieu of wages. Ellis (1997) estimates that roughly 30 million people are covered under the employer-based scheme. Some detail on coverage, type of benefits and provider payment is given in Appendix 4.

Health Insurance Schemes in the NGO/Voluntary Sector

Besides the mandatory insurance schemes, employment-based schemes in the formal sector and private health insurance, other risk sharing arrangements include community-based insurance schemes, primarily for informal sector.

Based on the review of some of the NGOs by Bennett (1997) and Ford Foundation (1994), it was found that the beneficiaries of most of the schemes are defined both by geographical location and nature of work. Total coverage is estimated to be about 30 million (Ellis 1997). The schemes tend to cover all insured members of community

for all available services but have emphasis on primary health. Most of the schemes are financed from patient collections, government grants, donations and other miscellaneous items like interest earnings, employment schemes, etc. Most NGOs have their own facilities and/or mobile clinics to provide health care. In this case, the providers are paid wages and salaries. Some NGOs have FFS scheme for providers and providers are partly reimbursed by the NGOs. Many hospital-based schemes pay on a case basis or fee-for-service basis, or allocate all collected funds to the nearest provider on a lump sum basis. The administrative costs of the schemes in the NGO sector are generally low, varying between 3-5 percent for different schemes. Details on coverage, type of benefits and provider payment for some NGOs are given in Appendix 5.

Box 1 below summarises some of the features of the different health insurance schemes existing in India.

CRITICAL ISSUES IN CURRENT HEALTH INSURANCE MARKETS

An ideal health insurance market is the one where the insurers would charge an actuarially fair premium 'm', if the cost of medical care is a random variable with the mean m. A risk-averter would be willing to pay this premium 'm' and have a welfare gain (Arrow 1963). The insurers also have reasons for loading the premiums, as there may be some degree of risk aversion by insurers. Further, there is a cost of capital tied up because of the irregularity of payments an insurance company has to make and a need to cover the administrative costs. As long as the loading is not very high, the consumer will be willing to buy the policy.

The health insurance markets, however, face certain risks of insurance. The following section discusses the demand and supply side limitations with respect to the current health insurance markets existing in India and also the methods on how the risks are minimised in the case of private health insurance.

DEMAND SIDE LIMITATIONS

Moral Hazard

Moral hazard is a major demand side problem of health insurance whereby the demand for medical care increases because of the health insurance. Even though the person may not entirely be able to affect the occurrence of his illness,² the costs of medical care are not completely determined by the nature of illness suffered. The costs of the medical care would depend on the person's willingness to use medical services, the type of medical services and his choice of doctor. Insurance removes all the incentives for the patient to shop for a better price for hospitalisation and medical care.

Moral hazard can be assessed by looking at the average expenditures incurred under the various schemes as well as the utilisation of the facilities under the schemes. Under mandatory social insurance schemes, expenditure per beneficiary on medical care as well as cash benefits in ESIS dispensaries and hospitals was Rs. 285 in 1995-96,

² An extreme case would be that the person becomes so careless about his health that he does not bother to take preventive care, as he feels that he will be covered by insurance in event of illness. This is an ex ante type of moral hazard.

BOX 1: SALIENT FEATURE OF SOME INSURANCE SCHEMES IN INDIA

Indicators	Mandatory Social Insurance Schemes		Voluntary Private Insurance- MEDICLAIM	Employer-Based Scheme	Community based Insurance/NGOs
	ESIS	CGHS			
Types of beneficiaries	Factory sector employees with income less than Rs. 6500 per month. Their dependants are also covered.	Employees of Central government-current and retired, some autonomous and semi-govt. organisations, MPs, judges, freedom fighters, journalists	Individuals and groups with persons aged 5 to 75 years. Children between 3 months and 5 years covered with parents.	Public and Private sector	People in the communities
Coverage	As per Table A1 (About 35.3 million beneficiaries in 1998)	As per Table A7. (About 4.4 million beneficiaries in 1996)	As per Table A11. (1.7 m persons covered). Urban poor and groups more likely to purchase policy.	about 30 million people	About 30 million. Normally quarter of the target group. (Table A15)
Types of Benefits	Medical benefits, cash benefits. Preventive and promotive care, and health education.	All OP facilities, preventive and promotive care available in dispensaries IP facilities available in government hospitals and in approved private hospitals on being referred.	Hospitalisation and domiciliary hospitalisation according to the sum insured. Exclusions and waiting period clause. Maternity benefits allowed with extra premium.	Categories under i) GHIP ii) Reimbursements iii) Lump sum payments iv) own facilities	Mainly preventive care. Also ambulatory and inpatient care.
Premium (financing of scheme)	4.75% of employees wages by employers 1.75% of their wages by employees 12.5% of total expenses by state governments	Varies from Rs 15 to Rs 150 per month based on salaries of the employees. Mainly financed by Central Government funds	Premium based on age and sum insured.	Depends on the above mentioned scheme	Financed by patient collection, govt. grants and donations. Premiums depend on the scheme -flat rate or income based.
Provider payments	Mainly salaries for physicians in dispensaries and referral hospitals. IMP paid on capitation basis. Hospitals have global budget financed by ESIC through state government	Salaries for doctors. Providers not allowed private practice. Treatment in private hospitals is reimbursed on case basis, subject to actual expenditure are prescribed ceilings.	Indemnity type. Insured pays to the provider who is later reimbursed according to the sum insured.	Salaries under the own facility scheme. FFS by patients, covered partly or wholly by the company	Mainly fee-for service
Administrative Costs	About 21% of revenue expenditure. For paying wages for corporation employees, and administering cash benefits, revenue recovery and implementation in new area.	Direct administrative costs including travel expenditure, office expenses, RRT - 5% of total expenditure. Part of salaries can also be charged to administrative costs.	Generally High. Low claim-premium ratio reflects that a large proportion of funds are utilised for running the scheme or kept as profits.	Depends on the scheme implemented by the company. Will be highest for own facilities.	Generally low (3%-5% depending on the scheme)

and under CGHS was Rs. 392 in 1995-96. In terms of utilisation of facilities, it is seen that in both 1987-88 and 1995-96, a larger number of cases were reported using free wards for hospitalised cases in government facilities as compared to paying for general and special wards. In 1995-96, more than 80 percent of hospitalised cases reported using free wards in both rural and urban areas (NSSO 1992, GOI 1998). This shows that moral hazard exists for hospitalised treatment in government free facilities.

Under private insurance (GIC), moral hazard is witnessed both in terms of the number of claims reported and average expenditure incurred per beneficiary. Claims reported under MC (which roughly indicates the hospitalisation episodes) were higher at 52 per thousand³ as compared to the average number hospitalisations in urban areas, which were 20 per thousand in 1995-96 (GOI 1998). Further, in 1995-96, the amount settled per claim (which would represent expenditure incurred per episode of hospitalised illness) is higher under GIC at Rs. 7715 as compared to an average expenditure of Rs. 5344 per hospitalised illness in urban areas in private clinics (Table 1). This indicates that people with insurance are on an average using more hospitalised facilities as well as spending more per hospitalisation on medical care. This expenditure is expected to increase more in the recent years as GIC has done away with in-limits and pays according to the sum insured.

There are several ways by which the risk of moral hazard can be minimised in the private health insurance markets. GIC now offers incentives to reduce utilisation, such as a cumulative bonus of 5 percent on the sum insured is given for every claim-free year. Further, group discounts also change based on the claim premium ratio for the group. Data for the current years will be able to indicate whether the utilisation is changing with these features.

Further, private insurance companies can introduce features that can reduce the risk of moral hazard. Co-insurance, where a patient bears a certain percentage for every extra rupee spent on medical care reduces the incentive to seek expensive care. Deductibles, which are a certain minimum sum which the insured consumer has to pay out-of-pocket before the insurance company begins to pay, also deter unnecessary use, especially for small claims. Co-payments, which are a fixed proportional amount to be paid for every visit, reduce moral hazard by restricting the number of visits to the doctor. While the individual will prefer an initial deductible and then be covered 100 percent, the insurance companies will like co-insurance and co-payments to minimise the risk of uncertainty. Box 2 provides the risks and incentives that arise out of these different benefit packages.

Moral hazard can also be influenced by the mode in which the patients are covered for their insurance. The three different methods to cover health care costs are (i) prepayments- which are paid in kind in terms of medical services; (ii) indemnities based on fixed schedule; and (iii) insurance against costs subject to deductibles,

co-insurance or the maximum sum insured. The moral hazard problem is minimised in prepayment plans where the patient is bound with the closed panel and freedom of choice is minimal.

Another way to minimise the risk of moral hazard problem is to have third party control over the payments or introduce a system of gatekeeper (Chollet and Lewis 1997). In third party payments, the same group could provide insurance and medical services. A network of primary care physicians and specialists is established and the enrollee chooses from the primary care physicians. Specialist treatment is allowed only when the physician refers. This emphasises the use of preventive care and puts less emphasis on expensive treatment. Another way third party control occurs is by having an intermediary between the insurance company and the patient. This third party could collect premiums from the insured thereby providing group incentives and at the same time help in minimising the moral hazard by tying up with providers.

Reducing the supply of doctors, thereby increasing the waiting lines and waiting time for the patients can also reduce moral hazard. This of course affects the quality of service towards consumers.

Adverse Selection

Another problem visualised on the demand side in the insurance market is that of adverse selection where only the sick will buy the insurance. This problem arises because of the asymmetry of information and because of pooling of unequal risks – the whole concept on which the insurance is based. Persons with high-expected health expenditures are more likely to purchase insurance than those with less health expenditures. If equal premiums are charged, then those with low risks will prefer to be excluded, leading to an overall high premium for the balance. If not checked, this can take serious proportions and can lead to a breakdown of the insurance mechanism.

In India, adverse selection is evidenced in some NGO schemes as well as under the GIC MC policy. In the NGO sector, schemes that allow for enrolment throughout the year without any waiting period encourages people to join the scheme when they get sick (e.g. VHS, Madras). Some schemes minimise adverse selection by ensuring that certain minimum percent of the people in the village join the scheme (Creese & Bennett 1997).

Under the GIC MC policy, age-wise information on 45,169 policies indicates that the premium to policy ratio is lower than the average in age bands 5-45 and 71-75 (Ellis et. al. 1997). This may indicate an adverse selection among the lower age band as lower average premiums could be due to both a lower number of enrolments as well as due to the lower coverage of policy. On the other hand, lower premium per policy in age band 71-75 could be due to risk selection exercised by the company. The current GIC policy reduces the risk of adverse selection by charging different premiums from people of different ages and by

³ Based on the data for United India Insurance Company for 1995-96.

BOX 2: FREE CARE OR INSURED BENEFIT PACKAGE: FINANCIAL RISK AND INCENTIVES

	Risk borne by:		Incentive for	Functions	Limitations/ Advantages
	Insurer	Patient	Patient		
Free	All	None	Increase demand	Incentive for low income consumer	Affects freedom of choice of provider
Full user fee	None	All	Reduce demand	Incentive for provider to give best quality and good service	Increases inequalities
Deductible	Amount above deductible	Amount up-to total deductible demand	Reduce demand till deductible amount is reached, then increase	Deters unnecessary use and avoids the cost of administering small claims	Incompatible with preventive, low cost care, and for low income people who cannot afford
Fixed co-payment per visit	Full charge minus co-payment	Co-payment	Reduce demand for visits	Deters unnecessary visits for diseases with excessive incentives to visit doctors, e.g. mental care, dental care etc.	Low administrative costs for insurance agencies
Co-insurance (% of charges)	(1-X) % of charges	X % of charges	Reduce demand (Depends on % of co-insurance). Can be applied for all or some covered services.	Reduces incentives to use expensive care	High administrative costs for insurance agencies
Ceiling on amount paid by insurance	Amount below ceiling	Amount above ceiling	Reduce demand when ceiling is exceeded	Deters the use above a limit	Consumers may not be able to cover cost above the limit

Source: Prepared using information from Hsiao (1998)

encouraging group insurance. Group discounts vary from 15 to 67 percent depending on the size of the group.

Adverse selection can be minimised by having compulsory universal insurance or a risk rated premium. Encouraging group insurance according to geographical locations or occupation groups can also help to minimise adverse selection. Also, income redistribution with a longer time perspective, that is a life time enrolment, can help to minimise adverse selection.

Under Utilisation of Care

The discussion above on moral hazard has shown that private insurance is likely to lead to excess demand. So the question of under-utilisation is more relevant for the uninsured needy who may not have enough resources for treatment in private facilities. The estimates for 1995-96 show a strong positive association between MPCE (monthly per capita consumption expenditure) and rate of hospitalisations. Hospitalisations during the last 365 days by MPCE show that the number of persons per thousand hospitalised was four in the lowest income decile as compared to 37 in the upper most income decile in rural areas. The corresponding numbers were 12 and 38 in the urban areas. The estimated number of hospitalised persons differed significantly in rural and urban areas. The proportion of persons hospitalised, in fact, declined from 28 to 13 between 1986-87 and 1995-96 in rural areas whereas it increased from 17 to 20 during the same period for urban areas (GOI 1998). Many people in the rural areas

get excluded from hospitalisation because of the lack of facilities, especially for inpatient treatment in these areas. Under-utilisation is also likely to occur for some treatments that have positive externalities like communicable diseases, immunisation, maternal care etc.

Under-utilisation by the insured occurs if the facilities covered by the insurance are not satisfactory. Under-utilisation of the capacity, especially for inpatient treatment seems to be an endemic feature of the ESI scheme. The bed occupancy rate was only 52 percent in 1997-98. The various factors underlined for these include over-planned hospitals in certain areas as well as: badly located, under-staffed, and overall unsatisfactory level of services provided. Inadequate speciality and super speciality services, frequent and unnecessary referrals to government hospitals, and inadequate supplies are other reasons listed for poor utilisation (GOI 1999a).

The utilisation of care by the poor and needy can be improved if large costs associated with hospitalisation can be borne by the government or the insurance company. The utilisation of subsidised government facilities will depend on the quality of care accessible there. Information, education and communication can play important role in making people aware of the benefits of keeping healthy and in encouraging use of preventive care.

SUPPLY SIDE LIMITATIONS

Supplier induced demand (SID)

A symmetry of information in the health care market leads

to adverse selection on the demand side and supplier-induced demand by the provider of services. Once the patient goes to a provider, the supplier can induce demand by certifying the necessity of a given treatment. The physician, who knows about the right amount of treatment for his patient for a particular illness could act as a limiting factor. However, he may not have any incentive to do so and may in fact prescribe more frequent visits, expensive medication, unnecessary diagnosis, private nurses and encourage a longer stay in the hospital to possibly make more money himself. The supplier-induced demand may arise out of the target income hypothesis or the increased availability of doctors. Whatever be the method or the reason, SID is likely to increase the costs of care and can be dealt with by changing the payment mechanism to the provider.

Under both CGHS and ESIS, doctors are paid their salary and hospitals have their budget, giving no incentives to providers to induce demand. However, it is noticed that the average length of stay is higher in public hospitals and in paid wards as compared to private hospitals and free wards (NSSO 1992).

Under the GIC indemnity scheme, patients are reimbursed by the insurance agency after they have made the payment to the hospital. As there are no in-limits, hospitals can charge and have the incentive to over charge and indulge in any of the practices mentioned above. The average length of stay (ALS) and unit costs are likely to be higher with insurance rather than without insurance. As mentioned earlier, average expenditures with insurance are higher at Rs. 7715 as compared to an average expenditure of Rs. 5344 per episode of inpatient treatment in private facilities in urban areas. It may, however, be difficult to say whether higher expenditures are due to moral hazard or due to supplier induced demand.

Supplier induced demand can be influenced by the method of payment to the physician and the hospital (Box 3). Under the fee for service system (FFS) and capitation system, providers have an incentive to increase the number of patients. The FFS system also provides incentives to providers to increase the number of visits, decrease the amount of service per chargeable visit, and report a higher illness severity. Salary payments for providers and global budgets for hospitals provide incentives to decrease the

BOX 3: PAYMENT MECHANISM FOR PHYSICIANS AND HOSPITALS: FINANCIAL RISK AND INCENTIVES

Payment mechanism	Basket of services paid for	Risk borne by		Provider incentive to			
		Payer	Provider	Increase number of patients	Decrease no. of services per chargeable unit of care/consultation	Increase reported illness severity	Select healthier patients
FFS (P & H)	Each item of service & consultation	All risk borne by payer	No risk borne by provider	Yes	No	Yes	No
Case payment (e.g. DRG) (H)	Payment rates vary by case	Risk of number of cases and severity classification	Risk of cost of treatment for a given case	Yes	Yes	Yes	Yes
Admission (H)	Each admission	Risk of number of admission	Risk of number of services per admission	Yes	Yes	No	Yes
Per-Diem (H)	Each patient day	Risk of number of days	Risk of cost of services within a given day	Yes	Yes	No	No
Capitation (P & H)	All covered services for a person in a given period	Amount above "stoploss" ceiling	All risk borne by provider up to a given ceiling (stoploss)	Yes	Yes	No	Yes
Global budget (H)	All services provided by a provider institution in a given period	No risk borne by the payer	All risk borne by provider	No	Yes	No	Yes
Salary (P)	For one week or one month work	All risks	No risks	No	Yes	No	Yes

Source: compiled using Hsiao (1997)

Note: P and H in the first column refer to the physicians and hospital payment mechanisms respectively

number of visits and also the quantity of service per treatment episode. For insurance agencies, a direct tie up with the hospital or reimbursing the provider according to the 'Diagnosis related groups', or standardisation of treatment and paying for that could reduce the unnecessary supply.

Cost Control Measures

Insurers exercise various options in their health plans in order to control costs. Since the program's income is constant, skimming, skimping, caps on benefits, excluding certain high cost diseases and pre-existing conditions, waiting periods, are some measures used by the insurers to lower the price of the health insurance contract.

Skimping

Skimping is a supply side problem where the insurers can deny or delay benefits to the sick for the services needed or demanded.

Under the mandatory ESIS and CGHS, the government undertakes insurance and facilities are available to those who are covered. However, benefits are indirectly denied to the sick as available facilities are poor and doctors are either not available or there are long waiting lines, leading the beneficiaries to use private facilities (Reports of the evaluation committee, GOI 1999a). By not having the facilities in all areas, some of the beneficiaries, like retired persons, are denied benefits under CGHS.

GIC exercises skimping by not covering diagnosis that is not related to subsequent hospitalisation. Treatment arising from or traceable to pregnancy/childbirth including caesarean section is not covered. Domiciliary hospitalisation is not allowed under maternity benefits extension. Further, skimping is exercised by denying or delaying reimbursements of claims.

Outpatient treatment is normally denied coverage by private insurance since it can be easily influenced by the doctor as well as the patient. For example the number of visits can be increased, expensive medicines can be prescribed, etc. Covering out patient treatment involves high cost of administration for insurance agencies. Insurance companies can influence outpatient visits by imposing a high deductible for a treatment. Provider payments can also indirectly influence the outpatient visits.

Skimming

Skimming or creaming is a supply side incentive practised by the insurance companies to insure the more healthy people and exclude the less healthy. This phenomenon, also known as risk selection, is to ensure the profit motive and financial stability of the company or the provider. Insurance companies indulge in risk selection through underwriting rules and targeting products to low risk groups.

ESIS and CGHS do not indulge in skimming, as it is mandatory for them to cover all eligible employees and their families. Risk selection is exercised by GIC by varying rates of premiums according to the age under the

MEDICLAIM scheme and varying premiums based on the relative risk of jobs or activities of the person in the accident insurance policy of GIC. Further, GIC has been encouraging the group insurance policies which are mainly offered to employees, their spouse and their children, which is mainly the healthy group. By offering to include dependent parents in such schemes it can reduce some amount of skimming.

Regulatory methods can be used for controlling risk selection. Government could instruct insurance companies to open the plan to everyone in the community and to charge uniform premium from participants in broad geographic and demographic group without regard to health status (community rating). Risk adjusted premiums could also help to discourage skimming.

Skimming (creaming), skimping and dumping are the three strategies that the providers adopt in response to their reimbursement systems (Ellis, 1997). While the cost based reimbursement results in over-provision to all types of patients, prospectively paid providers using case payment (e.g. DRG) skim low severity patients and skimp high severity ones. Skimming would be noticed under the payment made on admission or capitation. It is only under the fee-for-service system and per diem payment system that the providers do not have incentives to select only healthier patients. The effect of provider payments on skimming is shown in Box 3.

Exclusions

Insurers keep the premiums under control by excluding certain diseases for the entire period of the contract and pre-existing conditions for a stipulated period. GIC has several exclusion clauses in their health insurance scheme. First, the scheme covers only hospitalisation and domiciliary hospitalisation up to a certain limit of the sum insured. There are caps on reimbursement according to the sum insured. All pre-existing diseases and those contracted in the first 30 days of the first year of policy are excluded. Certain diseases like cataract, hysterectomy, hernia, piles etc. are excluded for first year of the policy. Eye check-ups, dental treatment, convalescence, naturopathy treatment, AIDS treatment are not covered in the policy at all.

Each of these methods can create problems for certain consumers. The payment mechanism to providers can influence these cost control measures. While salary and global budgets provide no incentive to the physician or hospitals, the FFS and case payments provide incentive to report increased severity of illness (Box 3). Further, exclusions for pre-existing conditions should not be there for the lifetime and should be limited. There should be guaranteed renewability and continuity of coverage.

Box 4 summarises some of the market failures in health financing. It presents the demand side limitations and supply side limitations, their effects, and some measures used to correct such failures.

BOX 4: MARKET FAILURES IN FINANCING HEALTH

Market failures	Consequences	Measures used to correct failures
Demand Side Limitations		
Moral hazard	Overuse of services by patients.	Deductible, co-insurance, co-payments etc. Gatekeepers, Waiting lines
Adverse selection	Little risk pooling. No insurance market will exist. Only some insured.	Tax subsidy, compulsory universal coverage. Lifetime enrolment
Under-utilisation of health care	Under use of services/treatments with lumpy costs by poor and also for preventive care and diseases with externalities.	Education, Information and Communication. Free or subsidised care.
Supply side Limitations		
Supplier Induced Demand	Increased demand by patients. Raises costs of care.	Use provider payment mechanisms like salaries, global budget, and case payments (See Box 3)
Risk selection (Skimming)	No insurance for disabled, sick, poor and elderly	Open enrolment, Community rating, Risk adjusted premiums for individuals
Skimping	Deny benefits to the sick	Social Insurance
Exclusions	Exclude pre-existing conditions and certain diseases for stipulated period or life of the contract.	Lifetime and compulsory insurance. Guaranteed renewability
Monopoly or insurance cartel	Excess profit, poor quality products, underproduction	Anti-trust laws

OTHER FACTORS INFLUENCING THE HEALTH INSURANCE MARKET

Costs of Care

Both the demand and supply of health care services can influence the cost of health care. The costs of medical care are influenced by the person's willingness to use medical services, the type of medical services and his choice of doctor. Depending on the kind of insurance cover, the patient tends to use or over use the health services. On the other hand, the suppliers affect the costs by prescribing more visits or expensive treatments.

Under ESIS, costs are controlled by placing a ceiling on the expenditure at Rs. 500 per year per IP out of which Rs. 165 is earmarked for drugs (this is proposed to be increased to Rs. 600 per year per IP (GOI 1999a)). Even the IMP is paid only Rs. 5 per IP per month. In 1995-96, total expenses per beneficiary were Rs. 260 and cost per inpatient per day was Rs. 396 (ESIS 1996). In 1986-87, ALS was reported to be about 17 in government facilities (NSSO 1992). Using the same ALS, cost per hospitalisation episode can be estimated to be Rs. 6732 which is higher than the expenditure incurred for inpatient treatment in both public and private facilities.

The cost of care under CGHS was Rs. 338 per beneficiary in 1995-96. The cost to premium ratio is 140 percent and the scheme is highly subsidised with contributions from the government. In order to keep the costs under control, ceilings are placed for reimbursements for different treatments in private hospitals.

The costs of care under GIC were kept low by having in-limits and by putting a ceiling on the maximum reimbursable amount. However, even with in-limits, the

cost of treatment was higher with insurance as compared to average expenditure for inpatient treatment in private facilities. Under the new policy, the in-limits have been removed and the maximum reimbursable amount has increased which may increase the costs even further.

Employer-based payments control costs by having limits on reimbursements or lump sum payments.

In the NGO sector, the costs of care are covered from their revenues and donations. The costs are kept low as administrative costs are low and most NGOs spend about two-third to three-fourth of expenditure on low cost preventive and promotive programs and rest on curative care (e.g. in AHRT and SEWA, Ford Foundation 1990). The major cost is on salaries, drugs and supplies.

Introducing co-insurance, deductibles and co-payments, or limits on reimbursements can moderate costs of care by indirectly affecting the demand for medical care. Further, provider payment mechanisms can influence the health care costs on the supply side. Fee-for-service is an inflationary payment mechanism that leads to over-treatment and prescription of expensive medicines by the physician. Other payment mechanisms have smaller incentives to increase the costs directly but influence the length of stay or the number of visits.

Quality of care

The quality of care provided by the physicians again depends on the payment mechanism to the physician and the hospitals. While the fee-for-service mechanism or the user fees have the maximum incentive for the providers to give the best quality of care, salary, global budget, capitation and per diem have incentives to reduce the quality of care. The per diem payment gives incentives to

providers to increase the average length of stay but gives nothing to improve the quality. Capitation and admission gives incentives to reduce both quantity and quality of service for every patient seen (Box 3).

Under the government subsidised system and mandatory social insurance system, the payment mechanisms are mainly global budgets for hospitals and salaries for physicians. Under both these mechanisms, quality and efficiency are likely to be low. For example, even though ESIS has standard norms for establishment of hospitals/dispensaries, staffing and equipment, there has been a problem of understaffing, obsolete equipment, poor quality of medicines and medical supplies, and poor quality of services. There have been recommendations to improve the quality in ESIS by privatisation of management in ESI hospitals, improving quality checks for drugs, replacement of obsolete equipment, motivating the staff, entrusting more powers with the hospital's superintendent, and having proper staffing system to ensure all support staff is available. Allowing super-speciality treatment for ESIS beneficiaries in private facilities has been a step towards quality improvement (GOI 1999a).

CGHS has taken steps towards quality improvement by allowing treatment for hospitalisation in many good private hospitals that have been recognised by the government. Medical audits for private hospitals are proposed under the MOU currently under consideration. Treatment taken at these places is directly paid by the government or reimbursed to the patient, giving more freedom of choice to users.

GIC offers the best quality within the amount insured. More freedom of choice is provided by removing all sub-limits within the sum insured. Further, GIC has a fairly high ratio of percentage of claims settled to claims reported at about 90 percent. However, the claim settled to the premium ratio is low implying a high retention ratio.

Private insurance ensures good quality care by allowing a greater freedom of choice of treatment in high quality tertiary hospitals. Even though there is no evidence to show better quality in private hospitals, site visits suggest large private hospitals run efficiently with excellent diagnostic and infrastructure facilities (Naylor et. al. 1999).

Consumer Redress Mechanism

Consumer redress mechanisms are important to ensure that proper quality of care is made available to the patients and that the insurance company pays the legitimate claims on time.

Under ESIS, there are tripartite regional boards and local committees with representatives of workers, employers, state government and ESIC. These committees conduct periodical reviews and inspections and look into the complaints of insured persons. However the complaints of the beneficiaries are not properly monitored. There are suggestions to set up Local Medical Benefit Councils to decide matters at the local level. Even though ESIC is responsible for lapses in the services, it passes the buck to

the state governments, which is a poor practice (GOI, 1999a). Under CGHS, there is a three-tier system to look into the complaints of consumers. Grievances can be brought to the notice of area welfare officers, zonal officers, or finally, to the head quarters. GIC's mechanisms to look into consumer redress is in accordance with the provisions of the Indian Arbitration Act, 1940 as amended from time to time and for the time being is in force (as per clauses 5.10 and 5.11 of the MEDICLAIM insurance policy of United India Insurance Policy).

Simplified consumer redress mechanisms are very important under the private insurance system so that the beneficiaries do not suffer with respect to their claims being paid and the services they receive.

Health Management Information System

A health insurance company should typically be using actuarial methods based on epidemiological data from different regions cross-classified by segments and socio-economic classes to calculate their premium. The paucity of such data for India inhibits the calculation of probabilities of diseases for different sections of individuals. Hence, the calculation of premiums is not based on the actuarial methods but is dependent on other considerations. GIC has based its premium on the consideration of claims incurred. Recently, it has adjusted its premium by age. Again, CGHS and ESIS use no actuarial information but base their premiums on the sliding scale of income. CGHS depends heavily on the central government funds to subsidise the scheme. Voluntary schemes normally have a flat rate based on the ability of the community to pay premiums. Better epidemiological data are required for private insurance to calculate actuarially fair premiums.

Options for Risk Pooling

The major objectives of health financing in any country are to provide universal coverage in terms of both affordability and accessibility of health care services to the entire population, ensure equity in financing, control costs, take care of the consumer choice and ensure reasonable quality of health care services. In order to attain these objectives, the country has to choose from different methods of financing which could be general taxation, earmarked taxes, social insurance, voluntary community insurance or private insurance. These methods have their own strengths and weaknesses in achieving the above objectives and handling the risks of insurance. Box 5 enlists these financing options and evaluates them against the objectives and risks of insurance.

While considering the options for risk pooling in India we must take into account some of the important features of the Indian economy, which include:

- population is almost a billion
- only 26 percent live in urban areas
- low density of population in rural areas (One-seventh of urban areas)

BOX 5: ASSESSMENT OF DIFFERENT METHODS OF RISK POOLING IN HEALTH CARE

Indicators	Gen. taxation (gov t. financed and delivered)	Social Insurance (Mandatory) (Financed & delivered)	Voluntary community	Private Insurance insurance
<i>In terms of major objectives fulfilled</i>				
Universal Coverage	Yes	Yes	No	No
Equity in access	Somewhat high	Moderately high	Moderate	No
Equity in finance	Progressive	Slightly Progressive (depends on how premium is calculated)	Moderately regressive. Normally a flat rate premium for the community	Very regressive
Incentive to control cost	Yes	Yes	Yes	No
Incentive for quality assurance	Low	Generally low	Moderate	Good
Consumer choice	Low	Low	Moderate	High
<i>Risks Involved</i>				
Moral Hazard	Yes if quality is good	Yes if quality is good	Yes if no payments have to be made after the premiums	Depends on other payment (Box 2)
Adverse Selection	No	No	Yes	Yes
Risk selection	No	No	Generally low	High
Skimping	No	No	Low. Normally covers primary care and some tertiary care.	High
Supplier-Induced Demand	No (Normally salaried doctors and global budgets)	Depends on payment to the provider (ref. Box 3)	Depends on payment to the provider (ref. Box 3)	Depends on provider payment (Box 3)
<i>Other Factors affecting the financing mechanism</i>				
How are contributions rated ?	Income	Income	Flat rate. Community rated	Risk rated
Do contributions determine benefits ?	No	No	Yes	Yes
Collection of revenue/contributions	Difficult for unorganized and rural sector	Difficult for unorganized and rural sector	Difficult for people not interested in joining the scheme	Possible
Profit Incentive	No	No	Weak	High

- high infant mortality rates (72 per thousand)
- one-third of the population is below the poverty line
- about one-third of the population is illiterate
- only 28 million are employed in the organised sector
- 5 percent of GDP is spent on health care.

Given this scenario, and coupled with the fact that there are trade-offs between different objectives like equity, efficiency and control of health costs, it becomes challenging to achieve the stated objectives by using different methods of financing. While achieving universal coverage with equity is one of the major goals of the economy, yet people expect to get good quality care at reasonable costs. In this context, no one method of risk pooling is adequate to meet the stated objectives and a mixed system of financing is required which has already evolved in India.

The discussion below examines different financing options existing in India and considers how far they have been able to achieve the given objectives and handle the risks of insurance.

Public Financing and delivery

As observed from Box 5, the tax-financed approach can provide universal coverage with equity in access and finance. Costs can be kept under control by having salary payments for providers and global budgets for the hospitals. However, it is difficult to provide freedom of choice of providers and ensure good quality care with limited public budget. Contributions do not determine the benefits. Contributions are income rated and deducted in the form of taxes and put in a common pool for different uses. Not everyone pays taxes and hence, does not contribute towards the common pool of resources. Risk of moral hazard is likely to increase if quality of care is improved. As every one is likely to be covered, the problem of adverse selection and risk selection does not exist.

In India, government financed and delivered health care is based on progressive tax structure and meets the objective of equity in finance. There is free and universal coverage of health care provided through a network of dispensaries and hospitals all over the country. Public hospitals play an important role in providing free care to

lower income groups. However, these are few and mostly located in urban areas. They are grossly under-funded and over-utilised and the rich are able to corner large benefits. On the other hand, poor quality of care in primary health facilities in rural areas leaves primary health centers largely under-utilised. Further, a relatively thin density of population in large rural areas burdens the government budget. Keeping in view the resource constraint and the positive externalities associated with preventive care, emphasis is shifting from curative care to preventive care, which helps to cover a larger population.

Separating delivery from financing can be one option under the public financed system. It is hoped that the proper monitoring of private providers can help not only in improving the access but also provide more freedom of choice to consumers. The other option could be to continue with public providers while incorporating more incentive based payment systems.

Mandatory social Insurance

This scheme can provide universal coverage and can ensure equity in finance if premiums are graded according to incomes. Costs and quality of care can be controlled through payment mechanism to the provider (Box 3). Moral hazard could be minimised by introducing supplementary payments for expensive treatment. Compulsory and lifetime enrollment can help to reduce the risk of adverse selection. Supply side limitations can be influenced through provider payment mechanisms. Consumer redress mechanisms can ensure good quality care at the cheapest rates.

In India, the social insurance is limited to only a small proportion of people in the organised sector and to central government employees. With a large rural and informal sector, social security approach will have its inherent problems. There will be problems in assessing the incomes of people and collecting premiums from small, unregistered firms and from those in the unorganized industries and rural sector, just as there are problems in collecting income tax. Further, the consumer redress mechanism will not function effectively because of a large percentage of illiterate population.

A large industrial formal sector, increasing size of population in urban areas, growing incomes of the country and high population density are all the necessary factors to expand the employment based social security approach.

Risks can also be pooled by maintaining the compulsory 'medisave accounts' just like the provident fund accounts for the employed. People should be made to pay a certain percentage of their incomes and be allowed to use the funds only for treatment of illnesses. Usage of funds should be allowed for lifetime if the person has contributed in that account for a stipulated period. Payment to the providers or reimbursements to the insured can be DRG based in recognised facilities subject to some maximum ceiling. For outpatient treatment, there could be some incentive mechanism like deductibles, co-payments to

reduce moral hazard. Another incentive could be to pay back a certain amount of the person's contribution along with interest in case the usage is below a certain amount after some stipulated time period. Different funds could be pooled at the national level for risk and resource equalisation.

Community-based Insurance

Community financing can complement formal social security schemes that cover regularly employed or self employed, particularly in rural communities. These are 'soft compulsory' implying that there is a local pressure on individuals to take a cover and also the term of insurance is long so that insurance funds could be planned as if the insurance is compulsory (Ensor 1997). Community based insurance schemes are important as they cover primary care, which is difficult for private insurance to administer. Another advantage of the community-based schemes is that they have low administrative costs and most of the expenditure is on providing drugs and paying doctors. For community schemes to sustain, the demand should be from within the community. Funds have to be locally managed and benefits and premiums should also be decided at the local level for people to trust the scheme. Inherent problems visualised in these schemes are low coverage, poor cost recovery and limited ability to protect the interest of the poorest both in terms of access and financing. Also, these schemes are based on the demand for those services/facilities for which there is local demand and not on professionally perceived needs.

In a low income country like India, where the industry based social security approach is difficult to implement across the entire economy, community led approaches might seem useful, especially for the rural population. However, they have had a low coverage. It has been found that the urban population benefits more. Wherever the schemes are operative, they have been able to provide a moderate quality of services. The premiums are normally community rated and most people are able to pay. The biggest advantage of most of these schemes is that the cost has been kept low and met from the revenues. However, with a large poor population in India (especially in the rural areas), some external support, whether from government or from donors is almost necessary for the schemes to sustain.

Private Insurance

Private insurance, which offers greater consumer choice and is perceived as providing better quality of services, arises out of consumer demand for economic security. It can neither provide universal coverage nor is it equitable in terms of financing. Premiums are risk rated to avoid adverse selection and generally higher risks are associated with the poor and the elderly. The chances of skimping and skimming are high to ensure profitability. Generally, high costs are said to be associated with private insurance but these can be controlled depending on the payment mechanism to the provider and hospitals. Private insurance is effective for high cost care. It will generally

BOX 6: ASSESSMENT OF DIFFERENT METHODS OF FINANCING HEALTH CARE IN INDIA

Options	Objectives Fulfilled	Risks involved	Constraints	Interventions suggested
Government Financed and delivered	<ul style="list-style-type: none"> High Universal Coverage Equity in finance-based on progressive tax structure Costs are controlled by having salaries and global budgets 	<p>Risk of moral hazard for free care.</p> <ul style="list-style-type: none"> No moral hazard because of poor quality. Under-utilisation of capacity. Risk if quality improves. No adverse selection because of compulsory insurance 	<ul style="list-style-type: none"> Poor quality in primary facilities. Poor accessibility in rural areas Rich manage to corner the benefits of the tertiary facilities No freedom of choice to consumers Difficult to collect revenues/contributions from rurals and unorganised sector 	<ul style="list-style-type: none"> Shift the delivery aspect from government to private providers or make the payment to the public provider more incentive based. Monitor and accredit private providers
Social Insurance Funds (Financed and Delivered)	<ul style="list-style-type: none"> Equity in finance as premiums are related to incomes Costs are controlled as providers are paid salaries & hospitals global budgets 	<ul style="list-style-type: none"> Moral hazard in some schemes Adverse selection, unless it is compulsory to join the scheme 	<ul style="list-style-type: none"> Coverage limited to only a small selection of the society Low freedom of choice of providers Poor quality of services delivered Difficult to collect premiums from rural & unorganised sector 	<ul style="list-style-type: none"> Shift provision to private providers or make payment to the public providers more incentive based. Have risk equalisation schemes to cover risks with different risks and resources Have medisave account/lifetime insurance
Voluntary Community Insurance	<ul style="list-style-type: none"> Low coverage but help to organize funds for relatively poor people Low cost, mostly spent on primary care Access affected by geographical proximity. Services available for all 	<ul style="list-style-type: none"> Moral hazard both in terms of visits and costs Adverse selection by people in age 18-45 Skimming exercised by varying premiums according to age and activity Exclusions for certain diseases and OP care SID under fee-for-service 	<ul style="list-style-type: none"> Flat rate or community rated premium. Not progressive Difficult to collect premiums from those not interested in joining the scheme External support from government or donors-almost necessary condition to sustain the schemes 	<ul style="list-style-type: none"> Organise funds at local level by involving local bodies/panchayats Make the schemes more attractive for everyone in the community to join Proper monitoring of the schemes
Private Insurance	<ul style="list-style-type: none"> Greater freedom of choice for provider Good quality of care likely as providers are paid like FFS system 	<ul style="list-style-type: none"> Very low coverage High costs of treatment Regressive in financing as premiums and risk rated Idemnity type of insurance makes it unattractive for many when they have to make large payments out-of-pocket and be reimbursed later. Exclusion for certain disease and pre-existing conditions 	<ul style="list-style-type: none"> Cover maternal and OP care Limit exclusions and guarantee renewals Have co-insurance, deductibles, etc. to minimise moral hazard Have prepayments or direct link-up with providers Allow freedom of choice in different systems of medicine Have anti-trust laws to prevent funds to form cartels 	

not cover services that are of high frequency and low costs, as the administrative costs of these will be very high. Outpatient visits can be covered by introducing high deductibles.

Private insurance has not found its way into India largely because of poor product and marketing and to some extent because of government policies. The existing private insurance in India is of indemnity in nature. This implies that a large section of population that cannot afford large payments for catastrophic illness at a time will not be able to afford this type of insurance. Private insurance will be ineffective in covering primary care because of a large population and the high incidence of risk associated with it. Lack of high quality inpatient facilities for rural areas questions the relevance of private insurance to cover a large section of the population. Further, private insurance may not be feasible on a large scale unless there is a sophisticated administrative infrastructure, uniform accounting procedures for hospitals, accurate clinical record system, computerized claim auditing, adequate health information and technical capacity to calculate premiums actuarially, know-how on underwriting methods to prevent adverse selection and risk selection' and procedures to detect fraud and abuse. All these procedures would require high administrative costs, which will have to be borne by consumers in the form of higher premiums.

A system aimed at providing cover to the poor, especially in rural areas, as well as giving supplemental insurance to those who demand quality assurance needs to be introduced. Standard benefit packages covering maternal, preventive, catastrophic and chronic care, with standard prices need to emerge to ensure social objectives. Exclusions should be limited and there should be a guaranteed renewal. Provider accreditation should be made public. Consumer redress mechanisms should be simple. Further, private insurance does not market products well in rural areas as it involves high administrative costs. NGOs can play a crucial role as an intermediary between the private insurer and the community.

Box 6 summarises (i) different financing options existing in India (ii) objectives and risks of insurance (iii) constraints faced under these different options and (iv) some interventions to remove the constraints.

POLICY OPTIONS FOR HEALTH INSURANCE IN INDIA

Having discussed the strengths and weaknesses of different financing options, and the trade off that exists between them, we can see that the optimum scenario for health financing in India would be a mixed one with the state as well as the private agencies playing an important role in the financing and delivery of health care. Some of the important aspects of the suggested system are discussed below.

An optimum health financing and delivery system for India

- In order to ensure universal coverage with equity, public financed system should continue to finance a basic minimum health package comprising preventive care and public health services for all, and some primary and curative care to cater to the needs of the poor.
- As this will have cost implications and as the government's contribution towards health is not very high, allocation to health should increase. Earmarked taxes for health care could be charged to ease pressure on public budget. However, the political feasibility of this has to be tested.
- Mandatory social insurance may be extended to more sectors at least to cover all employed.
- There is a need to reform ESIS and CGHS. There could be social insurance funds like the medisave accounts for the employed to cover them for lifetime.
- Income redistribution with a lifetime enrolment can help to minimise adverse selection and would pool the risks between the young and elderly.
- Risk equalisation schemes can cover groups with unequal risks and unequal resources. Cross subsidisation of funds at local, state or national level can be monitored by the government.
- Community insurance may be encouraged in rural areas. Maximum non-governmental resources should be organised and used in a transparent and accountable way. NGOs and local bodies can help in mobilising funds from the community for social insurance or private insurance. They can also play a role in ensuring that quality services are available at cheap rates and help consumers with redress mechanisms.
- Liberalise private insurance
- Need to establish products with standard benefits and standard prices upon which insurance companies should compete. Competition among the insurers can improve the quality of the product within the standard package.
- Package should include
- Outpatient treatment, maternal care, preventive care, and the treatment for chronic diseases and catastrophic illnesses.
- Assured renewability and offer of coverage to every one.
- Limited exclusions for pre-existing conditions.
- As far as possible, individual rating of premiums should be avoided.
- Quality standards and treatment protocols should be made public and quality ratings of providers should be available.
- When tying up with the private providers, provider payment should be incentive based to improve the quality of services and costs can be kept under control. The indemnity type of insurance especially for treatments with large payments must be avoided.
- Consumer redress mechanisms should be made simple and cheap.

- Regulations, reforms and a set up of basic administrative structure are prior conditions to liberalise India's private health insurance market. The monitoring of frauds and excessive fees are important.
- Under both public financed system as well as social insurance funds, delivery aspects must be either shifted to private providers in order to improve the quality of care and provide greater freedom of choice to consumers or make payments to public providers more incentive based. One needs to monitor and regulate the quality of care in both the private and public sectors of the economy.
- For outpatient care, patients should be allowed to choose from recognised private providers.
- Specialized curative care may be provided in government tertiary facilities or recognised private tertiary hospitals on being referred by OP private providers. Greater autonomy for public hospitals.
- Community health clinics run by NGOs are especially effective in providing primary care. These need to be encouraged but at the same time monitored by the government.
- Fee structure for both outpatient and in-patient treatment should be formalised and monitored.
- Proper monitoring and accreditation of private providers is required and quality ratings must be made publicly available.

Finally, one can conclude that there is no one method of risk pooling that would be suitable for the entire country, but a pluralistic approach needs to be followed for different areas and sections of society to meet various objectives to the best possible extent.

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APPENDIX 1

EMPLOYEES STATE INSURANCE SCHEME (ESIS)

Types of beneficiaries and coverage

ESIS covers factory sector⁴ employees earning less than Rs. 6500/- per month and also employees of shops, hotels, cinema halls, theatres and road transport undertakings employing 20 or more persons. The dependants of the insured employee are also covered under the scheme.

beneficiaries over 22 states and union territories (Table A1). The coverage over the last five years indicates a decline in beneficiaries per doctor as well as beneficiaries per dispensary (Table A2).

Region-wise coverage shows larger coverage in industrialized states like Mumbai, Tamil Nadu, West Bengal, Karnataka and Gujarat and relatively poor coverage for

TABLE A1

LEVEL OF COVERAGE UNDER ESIS: 1998

No. of Centres	640
No. of Employees	8,361,900
No. of Insured Women	1,524,100
Total Beneficiaries	35,290,350
No. of Employers covered	212,931
Local, Inspection and Cash Offices	1162
ESI dispensaries, Hospitals and Annexes	1620
No. of ESI Beds	23,692
Insurance Medical Officers	6,059
Insurance Medical Practitioners	2,885

Source: Annual Report: ESIS 1997-1998

TABLE A2

Level of coverage and facilities under the ESIS scheme over last 5 years

Years	Coverage			Facilities			
	No. of centers	Employers covered (in thousand)	Employers covered (in Thousands)	Beneficiaries (in Thousand)	No. of doctors	No. of hospitals & dispensaries	No. of beds
1994	617	162.1	6,627	28,692	9419	1545	23,348
1995	622	169.8	6,796	29,350	9380	1555	23,387
1996	629	190.9	6,613	28,335	9212	1564	23,470
1997	632	200.5	7,731	32,767	9120	1570	23,334
1998	640	212.9	8,361	35,290	8944	1577	23,692

Source: ESIS Annual report: 1997-98

The scheme presently covers 8.4 million employees with 18 percent women. It covers a total of 35.3 million states like Jammu and Kashmir, Himachal, Assam and Meghalaya (Table A3)

TABLE A3

REGION WISE PERFORMANCE OF ESIS: 1997- 98

State /Areas	Coverage			Per capita Expenditure	
	No. of Employers	No. of IPs	No. of Beneficiaries	Exp. On medical care	Exp. on medicines
Andhra Pradesh	12663	503500	1953600	800.16	118.88
Assam & Meghalaya	1235	43850	170100	1759.93	374.73
Bihar	5038	184050	714100	443.90	20.34
Chandigarh	1353	30900	119900	429.12	239.03
Delhi	23202	58500	2283400	733.07	174.88
Goa	1485	70800	274700	353.63	146.55

	170.34	703050	2727850	720.43	153.81
Gujarat	8495	404800	1570600	382.83	66.82
Haryana	483	35900	139300	350.75	139.40
Himachal Pradesh	290	16400	63650	81.41	6.38
J&K	14625	724700	2811850	400.50	126.48
Karnataka	9644	461950	1792350	576.88	163.11
Kerala	4833	256500	995200	787.97	235.67
Madhya Pradesh	45742	1653250	6234600	469.83	120.09
Maharashtra	2367	154700	600250	585.35	137.31
Orissa	673	35950	139500	934.70	88.78
Pondicherry	9579	435750	1690700	505.89	126.72
Punjab	6277	311650	1209200	538.16	136.24
Rajasthan	23350	1107350	4298500	471.02	118.99
Tamil Nadu	11277	484300	1879100	757.06	125.24
Uttar Pradesh	13290	887600	3443900	438.69	47.90
West Bengal	212931	9095450	35290350	547.84	
All India					

Source: ESIS, Annual Report 1997-98, GOI (1999)

TYPES OF BENEFITS

ESIS provides medical care as well as cash benefits through well-established hospitals and medical staff. The cash benefits, mainly to compensate for the wages lost due to medical reasons, include sickness benefit, maternity benefit, disablement benefit, dependent benefit, funeral expenses and rehabilitation allowance and are available on being recommended by ESI Medical officer. The medical services provided by the ESIS comprise a wide gamut of services ranging from preventive, promotive, curative and rehabilitative services.⁵ Services of the Indian system of medicines are also provided. Medical benefits can include outpatient care, hospitalisation, or specialist treatment. However, the package of benefits available in an area

of 12.5 per cent of the total expenditure on medical care in their respective states. In 1997-98, the contribution per employee was Rs. 1420 whereas the expenditure per family for providing cash and medical benefits was Rs. 1107 (Table A4). Medical expenditure per beneficiary was Rs. 112 and cash benefits per beneficiary were Rs. 91 in 1997-98.

Table A5 shows that the income of the corporation doubled between 1993-94 and 1997-98, mainly because of the increase in the contribution income. However, the medical benefits did not increase leading to a sharp increase from 14% to 31% in the ESI reserve fund.

Provider Payments

Out patient services are provided through service dispensaries or the panel system. Specialist treatment from

TABLE A4

Contributions Made and Benefits Received by the Employees: ESIS

Year	Contribution per Employee (Rs.)	Total Expenses Per Family (Rs.)	Total Expenses Per Beneficiary (Rs.)	% of Medical & Cash Benefits in Total Expenditure
1990-91	557.44	728.44	165.30	56.47
1991-92	572.06	841.27	190.20	67.20
1992-93	672.47	870.45	201.65	48.40
1993-94	749.87	1044.92	241.34	70.32
1994-95	766.74	1046.45	242.32	63.03
1995-96	796.25	1113.78	259.96	64.66
1996-97	781.83	708.36	182.57	77.22
1997-98	1419.9	1107.27	285.38	71.51

Source: Employees' State Insurance Corporation, Annual Reports: Various Years, New Delhi.

depends on the level of facilities available annoton the premium.

FINANCING OF SCHEME

The scheme is financed by employers who contribute 4.75 per cent of the wages payable to the covered employees, by employees who contribute 1.75 per cent of their wages and State Governments contribute a minimum

outside is allowed if referred by ESIS doctors. Inpatient treatment is generally provided through ESI hospitals. Some arrangement is also made with governmental and non-governmental organizations to provide treatment. The providers at ESIS facilities are mainly paid salaries. The panel doctors or the Insurance Medical Practitioners (IMP) are paid on capitation basis at Rs. 5 per IP per month. The IMPs are allowed to carry on their private practice. ESI

⁵ Those corporations that employ 10 or more workers with power and 20 or more workers without power fall under the Factory Sector. ESI Act is applicable to non-seasonal factories.

**TABLE A5 PERCENTAGE DISTRIBUTION OF
INCOME AND EXPENDITURE ACCOUNTS: ESIS**

	1993-94	1997-98
Income (in Rs. Million)	6924.7	14518
Contribution Income	71.8	81.8
Interest and Dividends	18.9	14.4
Rent Rates and Taxes	7.5	2.9
Compensations	0.2	-
State Govt's Share towards medical care incurred initially by corporation	1.2	0.4
Miscellaneous	0.4	0.3
Expenditure (Rs. million)	6924.7	14518
Medical Benefit	48.7	27.3
Cash Benefit	21.6	22.2
Other Benefit	0.1	0.07
Administrative Expenses	9.8	14.6
Provision for 1) Depreciation	0.2	0.2
2) Repair, maintenance of Hospital/dispensary	1.0	0.8
3) Rents and taxes	0.7	0.07
Provision for Capital Construction Fund	3.6	4.1
Net Excess transferred to ESI fund	14.2	30.6
	100	100

Source: ESIS : Annual Report

**TABLE A6 PERCENTAGE OF ADMINISTRATIVE COSTS TO EXPENDITURE ON
REVENUE ACCOUNT, CONTRIBUTIONS AND BENEFITS: ESIS**

Percentage of Admin exp. to	1994	1995	1996	1997	1998
Exp. on revenue account	1.5	13.1	13.8	15.3	21.1
Contribution income	13.7	14.2	115.7	15.2	17.9
Medical and cash benefits	13.9	16.5	17.3	19.8	29.5

Source: ESIS Annual Report, 1997-98

medical officers (IMO) are generally given non-practicing allowance. Some states allow IMOs to carry on their private practice also.

Cost of Administration

Administrative expenses necessary for running the

scheme have been increasing over the past 5 years. In 1997-98, the ratio of administrative costs to expenditure on revenue account was 21 per cent, ratio of administrative costs to contributions was 18 per cent and to benefits was 30 per cent (Table A6).

* The preventive services include immunisation, maternal and child health, and family welfare services. Health education and health check up camps come under the promotive services. Curative services include dispensary and hospital care, diagnostic facilities, drugs and dressing, surgical procedures, eyes and dental care. The beneficiaries are also provided with the rehabilitative services, aids and appliances as required by them.

APPENDIX 2

CENTRAL GOVERNMENT
HEALTH SCHEME (CGHS)

Types of beneficiaries and coverage

The scheme covers employees and retirees of central government, certain autonomous, semi-autonomous, and semi-government organisations. It also covers MPs, governors, accredited journalists and members of the general public in some specified areas. The families of the employees are also covered under the scheme. It covered 4.3 million beneficiaries in 18 major cities in 1995-96 (Table A7). City-wise coverage shows maximum beneficiaries in Delhi followed by Mumbai (Table A8).

TABLE A7 COVERAGE DATA
FOR CGHS, MARCH 1996

Cities	18
Families	956112
Beneficiaries	4,360,823
Allopathic Dispensaries	241
Other Dispensaries*	95
Total Attendance	15.58 millions
Total Expenditure	1475.7 millions

Source: CGHS (1999) Annual Report: 1995-96

*Includes Ayurvedic, Homeopathic, Unani, and Sidha dispensaries and also polyclinics

TYPES OF BENEFITS

The facilities under the scheme include outpatient care provided through a network of allopathic, ayurvedic, homeopathic, and unani dispensaries maintained for exclusive use by CGHS beneficiaries. Further, the scheme also ensures free supply of necessary medicines; laboratory and X-ray investigations; domiciliary visits, emergency treatment, antenatal care, confinement and post-natal care, advice on family welfare, specialist's consultations and hospitalisation facilities.

Premiums

Most of the expenditure of the CGHS is met by the funds from the central government. The premiums, payable by employees vary from Rs. 15 to Rs. 150 per month per family according to their income range (Table A9). In 1995-96, the contributions were 15.6 percent of the expenditure and Rs. 241 per family per annum.

Provider Payments

CGHS doctors, paramedical and other staff in dispensaries and family welfare centres are paid salaries from central government funds. Of the total expenditure, 32 per cent is spent on wages and salaries of the staff working for CGHS (GOI 1999). The providers under the CGHS are not allowed to carry on private practice. Treatment in semi-government

TABLE A8 CITY WISE FAMILIES AND BENEFICIARIES- CGHS: 1995-96

City	No. of families covered	No. of Beneficiaries	Percent attendance for allopathic clinics				Percent attendance for other systems of medicines			
			M	F	C	Total (in thousand)	M	F	C	Total (in thousand)
Ahmedabad	8082	36453	44	37	19	114.397	56	32	12	3.494
Allahabad	27943	159764	46	32	22	386.5	41	32	26	105.6
Bangalore	51156	214099	47	38	na	396.0	43	45	12	42.7
Bombay	102267	397229	38	37	25	881.9	41	39	20	77.2
Calcutta	109749	462208	46	39	15	911.1	45	30	25	30.1
Delhi	348274	1574695	37	36	27	6419.2	40	37	23	1146.0
Hyderabad	76650	450451	32	32	37	991.0	45	38	17	141.8
Jabalpur	11057	52410	47	33	20	164.5	0	0	0	0.0
Jaipur	22281	105633	42	34	25	300.3	47	34	19	23.1
Kanpur	41664	210524	38	32	30	585.4	32	31	38	80.2
Lucknow	12661	63473	38	34	28	286.7	46	34	20	71.5
Madras	33357	139692	43	40	18	555.8	47	41	12	46.5
Meerut	12187	68864	39	34	27	375.6	46	31	23	49.2
Nagpur	32586	150112	38	37	25	648.2	50	37	13	74.9
Patna	24850	120169	39	34	27	179.9	35	31	34	45.9
Pune	40257	150925	46	41	13	415.5	47	45	8	29.7
TOTAL	956112	4360823	39	36	25	13611.9	41	37	22	1967.9

Source: CGHS, 1999

Note: Bhubaneshwar and Ranchi exclusively for AG's employees. For Trivandrum and Guwahati, data was not available.
M-Males; F-Females; C- Children; T- Total

and certain certified private hospitals is reimbursed on case basis by the government according to the treatment provided, but have ceilings attached for different kinds of treatments. About 6 percent of total CGHS expenditure are used towards payment for professional and special services.

The expenditure of the CGHS during 1995-96 was Rs. 1,475.7 million or Rs. 297 per beneficiary. Of this total expenditure, 56.6 percent is incurred on material and supply which comprises mainly the drug expenditure. The expenditure incurred on office travel expenses, rent, rates, taxes, motor vehicles, and other charges can be taken to constitute administrative expenditure. This makes about 5 percent of total expenditure (Table A10).

TABLE A9

RATE OF CONTRIBUTION FOR SERVING CENTRAL GOVT. EMPLOYEES: CGHS

Pay Range per month (Rs.)	Contribution per month (Rs.)
Up to 3,000	15
3,001-6,000	40
6001-10,000	70
10,001 – 15,000	100
Above Rs. 15,000	150

Source: CGHS (1999a), MOHFW, GOI

TABLE A10

PLAN AND NON-PLAN EXPENDITURE UNDER CGHS: 1995-96

(Rs. million)

	Salary	Wages	Travel Exp.	Office Exp.	PPSS	Rent, rate & taxes	M.E.	M.S. charges	Other V	M&	Total
Plan Exp.	10.03	.03	.17	1.19	2.01	.86	4.74	13.96	2.27	.18	35.44
Non-Plan Exp	463.2	.71	6.72	21.71	84.62	1096	4.52	821.53	1.11	23.4	1440.32
Plan + non-Plan	473.2	.74	6.89	22.89	86.63	11.82	9.26	835.49	3.38	23.6	1475.77

Source: CGHS (1999)

Note: PPSS- payment for professional and special services

ME- Machinery and Equipment; MS – Material and Supply; MV- Motor and Vehicle

APPENDIX 3

PRIVATE INSURANCE SCHEMES

Types of beneficiaries and coverage: GIC offers medical insurance to groups as well as the individual through MEDICLAIM (MC) policies. Further, 'JAN AROGYA BIMA' scheme offers insurance to individual and families, mainly, to cover poor people. These policies are available to persons between the age of 5 years and 75 years. Children between age 3 months to 5 years can be covered if one or both the parents are covered concurrently. GIC also offers personal accident insurance policy to any person between the age

Voluntary insurance has had limited success in India. In 1995-96, the number of MC policies issued were 465 thousand covering 1.67 million persons (Table A11).

The Jan Arogya policy introduced in August 1996 covered 400,000 people by March 1997 (Naylor et.al. 1999). Further, the present MC scheme is confined mainly to the urban areas and males where about 95 per cent and 83 per cent of the policyholders are in the urban areas and males, respectively. As the policy mainly covers hospitalisation and most private hospitals are in urban areas, higher

TABLE A11

MC STATISTICS OF GIC AND ITS SUBSIDIARIES

Year	Policies Issued	Persons Covered	Total Premium (Rs. Million)	Claims Incurred Rs. Million)	Per-Capita Premium (Rs)	Amount settled per claim*	Claims % Premium
1990-91	165283	566791	278.37	137.08	491.13	6684	49.24
1991-92	191510	697018	344.73	186.6	494.57	3737	54.13
1992-93	252163	985674	489.18	246.29	496.29	4773	50.35
1993-94	440377	1276509	974.33	471.46	763.26	5938	48.39
1994-95	391002	1659069	767.91	491.53	462.85	8111	64.01
1995-96	465194	1668161	997.18	644.84	597.77	7715	64.67

Source: GIC, Bombay, Personal Communication. * Based on United India Insurance company

TABLE A12

NUMBER OF GIC POLICY HOLDERS IN URBAN AND RURAL AREAS AND BY GENDER

Sex wise	Urban	Rural
Male	32801	1855
Female	6988	194

Source: UNDP research study, GIC, Bombay, Personal Communication

coverage in urban areas is expected. (Table A12). Further, more than 73 per cent of the policyholders were in the lower income range (Table A13).

Types of Benefits

The MEDICLAIM and JAN AROGYA policy are annual policies. These cover hospitalisation and domiciliary hospitalisation for illness/diseases/injury contracted during the period for which the insurance is taken.¹ Full benefits are given to all insured as per sum insured opted for. Under the MC policy, family discounts up to 10 per cent and group discounts varying from 15 percent to about 67 percent depending on the size of the group are available.

TABLE A13

NUMBER OF POLICIES BY INCOME CATEGORIES

Income categories	Category of benefits chosen						Total	%
	I	II	III	IV	V	VI		
<2500	17432	3117	3278	2089	1044	804	27764	73.4
2500-5000	2623	701	874	249	158	232	4837	12.8
5001-10000	2912	478	404	97	53	84	4028	10.6
10001 and >	651	105	156	84	45	169	1210	3.2
Total	23618	4401	4712	2519	1300	1289	37839	100

Source: UNDP research study, GIC, Bombay, Personal Communication

of 15-70. It also offers Overseas Mediclaim Policies (OMP) and old age medical insurance scheme. Life Insurance Corporation, another public sector company introduced 'Asha Deep' policy in 1995 to cover four dreaded diseases i.e. cancer, paralysis, dialysis and heart diseases for individuals between 18-50 years of age.

For this reason, the group health insurance policies have become more attractive as compared to individual policies as reflected in chart 1.

Chart 1: Coverage of MEDICLAIM by GIC

The schemes have exclusions for pre existing diseases.

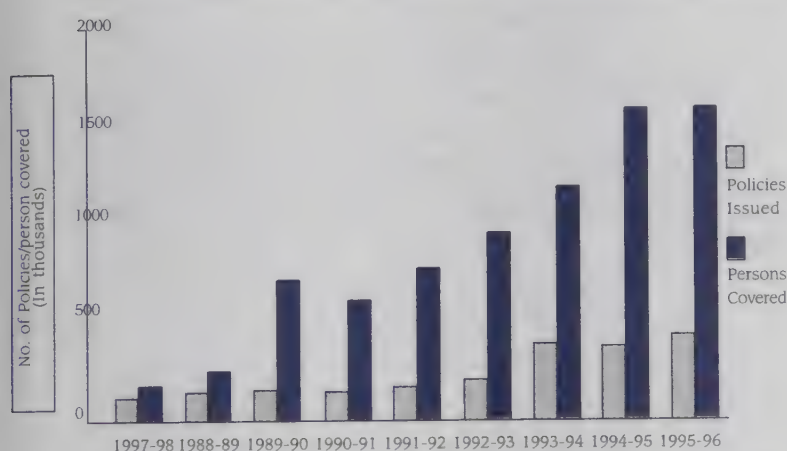
¹ The domiciliary hospitalization means treatment for those illnesses that would normally required hospitalisation but are treated at home under compelling circumstances as per doctor's advice. Domiciliary hospitalization reimbursement is a maximum of 20 percent of the total sum opted for

TABLE A14
MEDICLAIM STATISTICS FOR FOUR SUBSIDIARIES OF GIC: 1995-96

Year	Policies Issued	Persons Covered	Total Premium (Rs. Million)	Claims Incurred (Rs. million)	Per-Capita Premium (Rs)	Persons Covered Per Policy	Claims % Premium
National	87024	284464	191.77	122.69	674.13	3.27	63.98
New India	205387	657755	493.97	325.45	750.99	3.20	65.88
Oriental	60434	254295	38.67	22.69	152.06	4.21	58.69
United	112349	471647	272.78	173.61	578.36	4.20	63.64

Source: GIC, Bombay, Personal Communication

There is a thirty days waiting period clause and expenses for treatment of AIDS, naturopathy treatment, dental care etc. are not reimbursed. In most cases, statement from the individual is sufficient and medical check up is not required



prior to taking the policy. Certain diseases excluded in the first year of cover are covered, if policy is renewed continuously. Maternity benefit is available with extra loading in the premium. The scheme has a facility for health check up for 4 continuous claim free years. Incentives like no-claim bonus and tax-incentives are also there.

Premiums

Premium for MEDICLAIM scheme (individual as well as

group) is calculated based on the age of the proposer as also the sum insured opted for. The sum insured varies from Rs. 15,000/- to Rs. 3,00,000/- and premium varies from a minimum of Rs. 175 to Rs. 5770. The average per-capita premium was Rs.598 in 1995-96. Premiums for JAN AROGYA policy vary from Rs 10 to Rs. 140 per annum depending on the age of the subscribers. Under the accident insurance policy, the rate of premium depends on the risk group covered based on the occupation and the benefits the person opts for. The premium for Overseas MEDICLAIM insurance depends on the age of the person, duration of the trip and the plan the person opts for. The old age medical insurance scheme is like a medical savings account where the funds accrue during the person's life and are available later.

Provider payments

The scheme is of indemnity type, where the individual or the hospitals are reimbursed after the payments have been made or after the treatment has been provided. Expenditure above the sum insured has to be borne by the individuals as out-of-pocket payments.

Costs of Administration

The high costs of administration of the MC scheme, reflected in the low-claim premium ratio, were 35 per cent in 1995-96. This implicit high cost is due to selling costs and costs of commissions, acquisitions and several other types of operating costs.

APPENDIX 4

EMPLOYER-BASED INSURANCE

Types of beneficiaries and coverage

Employer managed facilities cover mainly the employees of large public and private sector undertakings and State-owned enterprises like railways and defense. Ellis (1997) estimates that roughly 30 million people are covered under the employer-based scheme.

TYPES OF BENEFITS

The employers could cover their employees under any one or combinations of the four major schemes: i) Group Health Insurance Scheme with GIC, ii) Reimbursement of actual expenses claimed by the employees for out patient care and hospitalisation, iii) Fixed Medical Allowance, monthly or annually, irrespective of actual expenses, and iv) In-house hospital facilities where companies have well-equipped, self-sufficient hospital services and out patient facilities in their own dispensaries and also provide medicines for their employees. Normally employees earning less than Rs. 6500 per month are covered under the ESIS scheme.

Expenditure on medical care for the sample companies works out to be Rs. 5.64 million per company or Rs. 1647.58 per employee per annum for 1988-89. On an average, public sector spends more at Rs. 2251 per employee per year whereas private sector spends only Rs. 1225.46 per employee per year (Duggal 1993). The study found that claims or reimbursement account for the single largest category of medical care expenditure.

Premiums

The rates of premium and extent of coverage vary for different employees in different companies. The company generally pays the premiums. However, some companies require their employees also to pay a part of the premium, which could be related to one's basic monthly salary.

Provider Payments

Payments to provider vary according to the benefits provided by the company. While under the first three schemes the patient incurs out-of-pocket expenditure and is later reimbursed by the company, for in-house facilities providers are likely to be employed by the company on salary basis.

APPENDIX 5

HEALTH INSURANCE SCHEMES IN THE NGO/VOLUNTARY SECTOR

Community-based insurance schemes, primarily for people in the informal sector, can have great relevance in countries with poor growth prospects and a growing informal workforce. A major challenge is to find ways and means in which accessible care of good quality can be organized using a maximum of non-government resources in a transparent and accountable manner.

In India, several schemes exist which are run by NGOs for providing health care for people working in informal sector and living primarily in rural areas. However, not all are documented. A review of 82 schemes in the non-formal sector undertaken by Bennett (1997) for different countries include 12 such schemes from India. In addition, a survey of some of the NGOs was carried out by Ford Foundation (1994) in the Anubhav Project. The following review is based on the experience of some of these NGOs.

Types of Beneficiaries and coverage

Beneficiaries of most of the schemes are defined both by geographical location and nature of work. Membership is individual or household based. Some schemes target just the women, e.g. SEWA. Evidence from several schemes points out that the very poor are seldom well represented in voluntary schemes unless subsidised by outside agency, usually the government. Secondly, rural participation is frequently lower in mixed schemes, which cover both rural and urban areas. Berman (1992) estimates about 5 percent of the total population is covered by the NGO sector. Ellis (1997) estimates the total coverage to be about 30 millions. Most of the schemes have a low coverage level - not more than a quarter of the target group. Table A15 gives the coverage for some of these schemes.

Types of Benefits

Some of the schemes have defined benefit packages but most identify benefits as all services available at their health centre and/ or hospital. Some schemes have exclusions; otherwise, they tend to cover all available services. An important aspect of NGOs services is the

provision of primary health care to all members of community through inpatient, outpatient treatment in health facilities or in medical centres and mobile clinics. For example, Streehitkarni in Bombay, KEM in Pune, CENI in West Bengal and VHS in Tamilnadu and Delhi emphasise on maternal, family planning and child health services. Some NGOs, like KEM in Pune and SEWA in Gujarat, also provide health education. The contribution of NGOs in curative health care is also substantial as many NGOs such as Banwasi Seva Ashram in Uttar Pradesh, Community Health Development Project in Maharashtra, VHS in Tamilnadu and Delhi, run their own dispensaries, clinics and hospitals.

Financing of the Schemes

Most of the schemes are financed from patient collections, government grants, donations and other miscellaneous items like interest earnings etc. Patient collections generally comprise premiums or fee-for-service payments. Premium in most of the schemes is on flat rate basis, paid annually and payment is mostly in cash. In more sophisticated schemes, premium is according to income. Sevagram, AGRT, VHS set premium on sliding scale according to income. The Sevagram scheme also allows payment in kind. SWRC allows monthly or quarterly payment. All the schemes rely on funds additional to those received from premiums, though the percentage from different sources varies in different schemes. For example, in AGRT, Pachod 22 percent were from government donations, 2 percent from donations and rest from patient collections. In SEWA-Rural, revenue contribution from government grants is 73 percent, patient collection account for 13 percent and donations 13 percent (Ford Foundation, 1990). The Seventh plan budgeted a government grant of Rs. 1500 millions for the NGO sector (Ellis et. al. 1997).

Provider payments

Most NGOs have their own facilities to provide health care. In this case, the providers are paid wages and salaries. Many hospital-based schemes pay hospitals on a case basis or fee-per-service basis. For example, SEWA uses the fee for service and members are reimbursed on the basis of bills. For most primary care schemes, all collected funds are allocated to the nearest provider on a lump sum basis.

Administrative Management and Costs

The administrative costs of the schemes in the NGO sector are generally low. The AGRT scheme, Pachod and SEWA-Rural, Jhagadia has administrative costs varying between 3 to 5 percent for different projects under the scheme. This low administrative cost is probably because the schemes do not indulge in too much marketing and most of the expenditure is used for the welfare of beneficiaries.

A major challenge is to find ways and means in which accessible care of good quality can be organised using a maximum of non-government resources in a transparent and accountable manner.

TABLE A15
COVERAGE FOR SOME SCHEMES IN
NON-FORMAL SECTOR IN INDIA

Name of the Scheme	% of target group covered	No. of Beneficiaries
Barpali	6%	—
Tribhovandas	16-20%	800,000
KSSS	18%	34,000
SWRC	25%	20,000
Sewagram	74%	19,450
Golpara	86%	1,250
SEWA		75,000 (1994)

Source: Bennett (1998)

PRIVATE ENTRY INTO HEALTH INSURANCE IN INDIA: AN ASSESSMENT

INTRODUCTION

The passage of the Insurance Regulatory and Development Authority (IRDA) Bill in the Indian parliament marks the latest phase in the move towards the privatization of the insurance sector in India (*Asian Age* 1999, Government of India 1999a). Up to now, the provision of various types of formal insurance has been under the exclusive control of the public sector (Government of India 1999a,b,c). The bill allows for the entry of private sector entities in the Indian insurance sector, including health insurance, and envisages the creation of a regulatory authority that would oversee the operations of various players in the insurance market (Government of India 1999a).

The private corporate sector has been quite enthused by this development. Several large health care providers and international health insurance companies have already positioned themselves to enter the market as soon as it is open to the private sector and the story is similar for their potential Indian partners (Sinha 1999a). Global insurance giants like Cigna and Aetna have entered into pacts with Indian partners and domestic firms are actively carrying out epidemiological mappings of the Indian population, investing in hospitals and conducting market surveys. One private consulting firm estimates that the health insurance market will grow to five times its current levels by the year 2005 (Dhawan 1999).

In contrast to the hectic activity in the corporate sector, the government appears to have been lethargic in anticipating developments, at least as far as health insurance is concerned. For instance, the IRDA bill itself contains no reference whatsoever to the health sector or to health insurance (Government of India 1999a). Nor is health mentioned in the nearly 175 pages of the Insurance Act of 1938, an amended version of which will come into force once the IRDA Bill is effected, and presumably is included under "miscellaneous insurance business" (Government of India 1999a,d).¹ This is broadly reflective of the policy environment in India, where health insurance continues to be neglected. As another example, in a report prepared by a government of India committee on insurance reform, there was exactly one reference to health insurance, on page 97 of a 104-page report (Government of India, 1994).

The apparent lack of attention to health insurance in

Indian government policy documents may reflect a somewhat sanguine view of the functioning of markets in health care provision, insurance and elsewhere.² The many problems with quality and consumer satisfaction in the existing Indian health system may have led to a belief that the entry of private insurance, especially in its managed care form (such as Health Maintenance Organizations (HMOs)) would lead to social net gains (Sinha 1999b; Srivastava 1999; *Times of India* 1999a). It may also be the case that the government expects any pertinent regulatory issues to be taken care of by the Insurance Regulatory and Development Authority (IRDA). The IRDA is supposed to protect the interests of policy holders, promote efficiency in the conduct of (all) insurance business, regulate the rates and terms and conditions of policies offered by insurers and direct the maintenance of solvency margins (for further details, refer to Government of India 1999a, pp.1-4).³

Whatever the reasons underlying the government approach towards the entry and functioning of the private health insurance sector in India, it is not always the case that private provision of health insurance works to promote the standard objectives of health policy.⁴ This is apparent from the economic theory of health insurance that points to problems of excess usage of health facilities, increase in inappropriate care, adverse selection and risk selection and their implications for the standard goals of health policy (see Section II below for further details). Moreover, the experience with private health insurance in developing countries such as Chile and Uruguay bears out some of these concerns (Medici *et al.* 1997, Ferreiro 1999). Even a well-designed regulatory set up for private health insurance such as in the United States may not yield entirely satisfactory outcomes. It has often been suggested that the high proportion of health expenditures to GDP (14.5 percent in 1995 (World Bank 1997))⁵ and the presence of 40-50 million uninsured Americans is associated with the strong presence of private health insurance in the United States (Chollet and Lewis 1997; World Bank 1993). Of course, all of this depends on the actual size of the private health insurance market that emerges, and a small size signifies smaller effects, at least in the short run.

In this chapter we assess whether the steps envisaged in the IRDA Bill including especially the provision for entry of

¹Section 2.13(B) of the Insurance Act refers to "miscellaneous insurance business" as the business of effects contracts of insurance which is not...included in..." (Government of India 1999d, p.4).

²This is obviously not a view shared by employees of the public sector insurance companies Life Insurance Corporation (LIC) and General Insurance Corporation (GIC), some two hundred thousand of whom went on strike on October 29, 1999 (Business Standard 1999).

³Statements by IRDA officials such as "the IRDA will deal firmly with those...who violate laws" likely form the basis for this position (*Times of India* 1999b).

⁴We shall not be concerned here with other impacts of reforming private insurance on the economy, such as enhancing the investment climate, infrastructure investment and employment (Sinha 1999c; Srivastava 1999).

⁵This is much higher than the proportion for other OECD countries ranging typically from 7 percent to 10 percent of GDP (World Bank 1997).

⁶Equity on health care can have many meanings including in terms of health outcomes, access to, and utilisation of health care facilities (Musgrove 1996). However, most of the measures are likely to be correlated with equity in the burden of health spending.

private firms will bring about an environment in the health sector sufficient for meeting India's health policy goals. The relevant policy goals are assumed to be a health care system that is not too costly, is of good quality, and with an equitably distributed burden of health care spending.⁶ Given that the financial burden of sickness upon the poor typically depends on government budgets that fund the public health sector and the personnel employed in it, the potential impact of the IRDA bill on government health services will also be a subject of our inquiry.

Taking the size of the private insurance sector as a given, we will first revisit the relationship between the increased spread of private health insurance and costs of health care, the quality of care, and the distribution of the burden of health care spending. Apart from indicating the implications of private health insurance for India, this analysis will also highlight the potential role of alternative regulatory tools that can be effectively utilized to address adverse implications (if any) of its spread. Second, the paper will describe the existing regulatory structure in India as it relates to health care provision and private health insurance and discuss its ability to promote national health policy goals. This is used to draw inferences about the potential impact of the entry of private health insurance in India and to suggest an agenda for regulatory reform in the health sector. Finally, we provide a set of estimates of the potential future size of the private health insurance market and discuss the implications of these projections for the satisfaction of health policy goals.

Our main conclusions are as follows: A review of the theoretical and empirical literature suggests that private health insurance may turn out to be somewhat more expensive and inequitable than a system of social insurance of comparable coverage, although the implications for quality of care are less certain. Even if a social insurance system were not feasible, many of the cost enhancing effects of private insurance and some of its impacts on the distribution of the burden of care can be ameliorated by appropriate regulation, if properly implemented. However, the regulatory setup as currently envisaged in the IRDA bill and related legislation will not be sufficient to promote the health policy goals as stated previously. This is partly because it is unlikely that the IRDA will take an active interest in regulatory issues specific to health insurance, given both the historical neglect of this issue among policymakers and recent pronouncements attributed to members of the currently existing "interim" IRDA.⁷ More importantly, the powers vested in the IRDA may not be sufficient to bring about the regulatory changes needed, even if taken in their broadest meaning and assuming an activist approach on its part. Important regulatory issues that IRDA could take up would require complementary regulations in health care provision to work effectively and these may not be under its control. In some cases, new legislation may have to be undertaken by the Indian Parliament. In others, better enforcement of

existing regulation by other organizations may be needed (as for accreditation, standards for medical institutions and malpractice), which is a real problem given the long history of poor performance. Finally, the IRDA is even less likely to be able to influence the impacts of private health insurance on the public health system and on the resultant quality of care available there. As a consequence, the effects of the introduction of private health insurance in India may turn out to be unfavorable although their magnitude will be small in the short run.

PRIVATE HEALTH INSURANCE AND COST, QUALITY AND EQUITY IN HEALTH CARE PROVISION AND FINANCING

This section has three parts – focusing on the relationship between the spread of private health insurance and issues of cost, quality and the equity in the health sector, respectively. The section relies heavily on the seminal work of Arrow (1963) and recent surveys of related literature by Einthoven (1997), Chollett and Lewis (1997), Musgrove (1996) and others.

Private health insurance and aggregate costs of health care

In theory, the introduction of private health insurance can contribute to increasing the aggregate costs of health care in several different ways. Most of the arguments in favor of increasing health care due to private health insurance have to do with some disparity in the information available to parties involved in transactions in the health care and health insurance markets.

In interactions between health care providers such as doctors and patients it is a given that the former have much better information about their patients' health status and future course of treatment than the latter. This, together with the prospect of being ill and accompanying psychological costs and loss of earnings makes the demand for health care fairly dependent on the course of treatment recommended by a physician. One consequence is that in a regime of pure indemnity insurance providers have an incentive to provide more care than may be medically appropriate. For the same reason the patient, or insurers for that matter, may be less willing to question the qualifications of the doctor as to his or her expertise (Arrow 1963, pp. 371-3). The problem will be greater in situations where the patient can choose his or her doctor and treatment freely and then present the bill to the insurer for reimbursement.⁸

The transaction between the insurer and the insured in the health market suffers as a result of inadequate or incorrect information as well. Once insured, an individual faces a reduced incentive to take precautions against poor health, much as a person with house fire insurance is likely to take less precaution in storing hazardous materials in her house. A sick person may also feel less compelled to control her consumption of health care and expensive diagnostic examinations if medical care costs are covered

⁷For instance the IRDA does not plan to interfere in the premiums set by insurance companies for their policies, leaving that to "market competition." (Times of India, November 10).

⁸ The insurers can, under an indemnity system, rely on a co-payments or co-insurance to curtail consumer use of care, however.

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by insurance. Moreover, doctors and hospitals may only be too willing to provide enhanced care in view of the discussion of the previous paragraph. Thus an increase in insurance coverage could lead to an increased demand for health facilities and personnel and push up the cost of providing health care.

The arguments outlined above hold true for any type of insurance regime, public or private, so it is unclear on this basis alone whether costs are likely to be higher in a private insurance system in comparison to public sector dominated financing.⁹ It might be argued, however, that public operated insurance schemes, which typically involve dual functions of the financing and provision of services may involve a myriad of restrictions on health care utilization, especially referral to higher order care. In India, government employees covered under the Central Government Health Scheme (CGHS) cannot obtain reimbursements for private care unless appropriate referrals have been obtained from authorized medical practitioners or the Director of CGHS (Government of India, Various; see also Table 1). A similar set of rules appears to hold for the state supported Employees State Insurance Scheme (ESIS) for workers employed in the organized sector in India (see Table 1). This process assumes that there is an effective referral process that curtails the usage of public facilities, or private care if permitted under the public scheme. Under CGHS, only about 6 percent of the total expenditure is accounted for by outside/private referrals suggesting that the process for external referrals may be effective in India (Garg 1999b, p. 34).¹⁰ However, this does not appear to be the case for referrals within the public system where the utilization patterns are biased towards public hospitals as against primary care facilities (World Bank 1995 and Mahal *et al.* 2000).

Managed care institutions such as health maintenance organizations (HMOs) that have emerged in the private sector combine the roles of the provider and the insurer and can therefore serve to cut costs. The cost-cutting mechanisms could include stricter referral processes, payments based on diagnostically related groups, capitation payments, and other methods of managing the utilization of health care services (Einthoven 1997; Phelps 1997). In the United States, such systems covered nearly 60 percent of the population in 1995 with the population coverage having expanded at rates of 12 percent per annum during the previous decade (Einthoven 1997). Similar institutions have emerged in Latin America – such as the ISAPRES in Chile and the IMACs in Uruguay – and on a miniscule scale in India (Gupta *et al.* 1992; Medici *et al.* 1997).¹¹ There is some evidence to suggest that the emergence of HMOs has led to cost-containment in the United States. California, the state which experienced the fastest growth of HMOs during the 1980-91, also saw the slowest expansion in the cost of care among all states at 3.7 percent per annum in the same period compared to the

United States' annual average growth of 6.4 percent (Phelps 1997).

To the extent that private insurance in the form of managed care can yield low cost outcomes in comparison to a fee-for-service system, the relevant issue for policy makers and regulators is to devise methods to promote their emergence. At one level such institutions might be thought to be a logical market outcome given their lower costs and no obvious declines in consumer satisfaction relative to fee-for-service systems (see below for impact of managed care on quality). However, the experience of the United States suggests that such an outcome is not a *fait accompli* and HMOs faced stiff resistance from medical associations and legislatures until the 1970s and afterwards. Much of this resistance had to do with the prevailing "guild free choice" model that supported the idea of free choice of health care providers by consumers. Indeed, right up until the 1980s many states outlawed settings whereby employers could offer their workers preferential terms of coverage if they used specific providers with whom they had a contract on grounds of being discriminatory against providers (Einthoven 1997, pp.198-9). HMOs got a boost in the United States when laws were passed requiring employers to offer at least one HMO option to their employees and as the government began offering its own employees the option of such plans (Einthoven 1997, pp.212-3). Further evidence on this issue is available from the health reform experience of Chile where ISAPRES (private insurers) have functioned mainly as pure third-party payers (Baeza 1998; Ferreiro 1999).

A second form of information asymmetry common to insurance markets is the fact that individuals are likely to know much more about their health status and future needs than insurers. Thus, people expecting to incur significant health expenditures in the near future will figure disproportionately among those who choose to get insured. This causes profit-oriented private insurance companies to adopt procedures that are often expensive to weed out bad risks via a process called *risk selection*. In Chile, for instance, where the population over 60 accounts for 9.5 percent of the country's population, the share of the 60 years-plus group in the population insured with private insurers was only 3.2 percent, with the rest being covered by the public sector (Baeza 1998, p.18). Similarly, the average family size in Chile is 4 members, whereas the average among ISAPRE members is only 2.3 (Ferreiro 1999).

The "administrative" costs resulting from this process of risk selection — essentially a deadweight loss — can be quite high relative to expenditures and usually are passed on to customers in the form of higher loading charges.¹² Those unable to obtain insurance at the higher premiums may then go back to the free public health system if access under this system is open to all, or to out-of-pocket payments. In sum, overall health care costs would be higher than under a comparable public insurance system (unless

⁹Of course, in the existing scenario where the bulk of health expenditures in India are out-of-pocket (nearly 80 percent (World Bank 1995), use may be limited much earlier by household or local community resources in comparison to a setting with expanded insurance, public or private.

¹⁰This does not rule out inequities arising in the sense that a small segment of the beneficiary pool may be using a disproportionately large amount of the external referrals.

¹¹ISAPRES are the Instituciones de Salud Previsional (Musgrove 1991) and IMACs are "Collective Institutions of Medical Assistance" (Medici *et al.* 1997).

¹²Loading charges can also include profit margins

outweighed by the inefficiencies of a public sector bureaucracy) where membership into the insurance scheme may be compulsory for designated groups.¹³ Regulatory methods to prevent risk selection must, per force, face up to the problem of adverse selection (of poor risks disproportionately seeking insurance) which may have implications for the financial viability of an insurance company. In this sense, market outcomes that lead to insuring large groups are desirable so that there is little to suspect a preponderance of poor risks in the applicant pool.¹⁴ Indeed, there is clear evidence that larger groups face lower administrative costs. In the United States, loading charges (defined as (Premiums/claims) less 1) typically range from 40 percent for individual insurance to 5-8 percent for group insurance (Phelps 1997, p.346; see also Table 2). In India, insurance plans offered by the General Insurance Corporation (GIC) offer discounts over individual premium rates that range from 15 percent to 67 percent for groups of size 50 thousand or more.¹⁵

Large group insurance is unlikely to address all motivations for risk selection. It will not, for example, address the problem of risk selection across small employment groups and the self-employed if there are profitable opportunities in those areas. It will also not adequately address the possibility of selecting among individuals who change jobs or whose insurance comes up for renewal. Seemingly in the realm of "unfair" exclusion from insurance, regulations that curb the denial of insurance coverage to these groups may affect the costs of selecting among risks, for instance by inhibiting insurer motivation to acquire individual-specific utilization data from other companies or carrying out expensive pre-selection tests. On the other hand, regulations that cap total overhead expenditure of insurance companies would be more likely to promote group insurance business than the administratively more costly individual-based insurance (Government of India 1999d).¹⁶ Employment based group insurance can also be promoted by insurance contribution-linked tax benefits given to employers without corresponding tax liabilities for the employees (but not if premiums are paid by employees), as in the United States (Phelps 1997, pp.349-54).¹⁷ In India, however, tax benefits can accrue both to employers and employees depending on who pays the premium.¹⁸ In this setting, employer paid premiums may still be desirable as a means to promote group insurance if corporate tax rates are higher than personal income tax rates or if there are returns to scale to employers from administering group insurance.

In developing countries, there is another information-related factor that could potentially lead to high health care costs. This is related to the financial health of health

insurance companies. In the absence of minimum capital reserves and incomplete epidemiological information about the population, there is a risk that insurance companies could be guessing wrong and charging premiums that are much lower in comparison to the benefits offered in a competitive environment.¹⁹ The problems would be exacerbated if get-rich quick companies were to invest their premium income in high-risk assets that are not aligned to insurance claim liabilities. The importance of health insurance and the dependence upon it of a large cross-section of the population means that the government is unlikely to accept even short-run scenarios where the companies can become bankrupt.²⁰ As a consequence, the government or the insurance sector may be ready to incur additional amounts in expensive bailout packages for sick health insurance firms, creating a disincentive for individual firm managers to perform financially, since their downside risks are covered to some extent.

Governments across the world have sought to address these concerns by setting a minimum set of conditions relating to management and personnel, actuarial analyses, solvency, working capital and investment profile; and a system for dealing with liquidations/takeovers. In most cases, there is a national level regulator to oversee the implementation of these conditions. Some of the relevant regulations prevalent in the United States and the European Community are summarized below in section III.

Aggregate cost implications of private insurance: Cross-country evidence

In this section, we examine cross-country data to check if increased health spending per capita is associated with increased private insurance, all else remaining the same. We use information on per capita income, health care expenditures and private and public insurance coverage for about thirty-one developed and developing countries for this purpose (for details about the sample of countries and data sources, please refer to Table 3). Of course, a macro-assessment of the cost impact of the private insurance sector using national level data is not straightforward since it is likely to be confounded by income effects, the type of public insurance available, the nature and implementation of regulations and the like. Our preliminary analysis does not rule out the possibility that private insurance may have a much smaller impact on health spending than one would suspect.

Column 1 of Table 3 reports the results of a regression of the natural log of health spending per capita on the proportion of population covered by private insurance. The magnitude of the coefficient suggests that health spending

¹³One key exception to the argument in favour of lower administration costs in social insurance is a system where social insurance takes the form of a contribution into a national fund, payments out of which are made to various "private" entities to insure the contributors. In this case, risk selection by these entities would continue unless appropriate regulatory measures are adopted (see Chapter III for further details).

¹⁴With the assumption that the group insured was formed for reasons other than to seek health insurance.

¹⁵These are the rates for Group Mediclaim Insurance plans (communication with Rashmi Sharma, New India Insurance Company).

¹⁶Under the insurance rules of 1939, management expenses for "miscellaneous" insurance cannot exceed the sum of agent commissions (limited to 10 percent of gross premiums) and a number ranging from 20-35 percent of gross premiums depending on the volume of business. There are some exceptions for newly established companies, however (Government of India 1999e, pp.21-23).

¹⁷This is likely to be the case of employers find it administratively costly to deal with individual insurance packages, e.g., if wage differentials based on insurance contributions were to be instituted.

¹⁸Individual policies account for only 6 percent of the entire privately insured population in the United States (Phelps 1997, p.349).

¹⁹Communication with Mr. Sikandar Khan (Member of Income Tax Tribunal).

²⁰The problem is likely to be exacerbated in an environment with many competitors so that scale economies in administering insurance may not be possible (see Baeza 1998; Musgrove 1996, p.54).

²¹The market would work by eliminating inefficient firms over time but in the case of insurance this may be a cost too high to bear for the government.

per capita is positively associated with the proportion of population covered by private insurance. Indeed, a one-percentage point increase in the proportion of population covered by private insurance is associated with a 7.8 percentage point increase in the costs of health care per capita.

Health spending, however, depends on many factors including income. Increased income may also lead to an increased demand for insurance, both public and private. Increased incomes may also lead to greater out-of-pocket health spending. Thus, at the very least, the regression analysis would have to control for the overall level of insurance (and/or income) in examining the impact of private health insurance. This reduces the coefficient on private insurance to statistical insignificance at the 5-percent level and its magnitude becomes small as well. Column 2 of Table 3 indicates that an increase in the proportion of population covered by private insurance of one percentage point is associated now with only a 0.7 percent increase in the costs of health care per capita, if variations in income are controlled for. The results remain unchanged even if we control for the type of health insurance coverage in operation – that is, whether it is an alternative or merely a supplement to an existing system of public health insurance (see Table 3).

Is this result reasonable? The United States is often held up as an outstanding example of a country with “very high costs” of health care, a fact that is often linked to its predominantly private health insurance system. In particular, the United States has a high spending on health per capita (US\$3,828 in 1995) in comparison to other OECD countries such as France (US\$2,600), Japan (US\$2,947), and especially the United Kingdom (US\$1,205) and Canada (US\$1,814) (World Bank 1997). On the other hand, it is worth noting that with some notable exceptions such as the United Kingdom, the *rate of growth* of health care costs in the United States has often fallen below that of many of the OECD countries. California, a state with much experience in managed care, experienced even lower rates of growth in health costs during the 1980s and 1990s. Thus, a popular text on health economics for undergraduate students remarks that “The very strong relationship between per capita medical care spending and per capita income is all the more remarkable, given the wide diversity in health care systems...” (Phelps 1997, p.621).

Quality and Cost-effectiveness of Health Care

In the sense used here, *quality* refers to the level of competence with which a given examination and treatment protocol is implemented by provider(s) – be it medical examinations, diagnostic tests, the quality of administered drugs, or hospital care. *Cost-effectiveness* refers to the efficacy of the treatment protocol itself, by a comparison of expenditures in relation to outcomes.

There is an extensive literature that summarizes the poor

quality of health care currently available to seekers of health care in India. For instance, patients both rich and poor tend to overwhelmingly favor the private sector when it comes to ambulatory care (ASCI 1996; World Bank 1995). This suggests the generally poor perception of the state of medical consultation available in the public sector, a fact confirmed by large shortfalls in personnel, equipment, and medicines in public facilities reported in primary health centers and sub-centers (Naylor *et al.* 1999; World Bank 1995). The situation is no better for workers with access to facilities under the ESIC (Employees State Insurance Corporation). ESI facilities are well known for their unresponsive staff and their poor state of equipment (ASCI 1996; Wadhawan 1987). Finally, the private sector itself is known for providing low quality health care. A study in two districts of Maharashtra found a large number of doctors practicing modern medicine without being qualified to do so, several hospitals that did not have even the basic infrastructure and personnel to carry out their functions, and operating without any licenses or registration (Nandraj and Duggal 1996). More recent studies of private medical hospitals in Calcutta and Bombay further confirm the poor state of private sector facilities, apart from highlighting the frequency of medically unnecessary procedures carried out on patients (Nandraj, Khot, and Menon 1999).

In addition to poor quality, there is reason to believe that some of the care provided is cost-ineffective. The obvious example is the much higher rate at which patients utilize outpatient departments of hospitals and other sources of advanced care in comparison to primary health clinics.²¹ The rapid spread of diagnostic centers in the public and private sectors (TN example) leads one to suspect the inefficient use of this technology in the provision of health care as well.

In a free market with no uncertainty about the outcome of treatment, one might expect higher quality treatment to be undertaken (subject to the usual constraints) as fully informed consumers choose the most effective doctors and medical facilities, ignoring the rest. However, a major problem in the health care market is precisely the uncertainty about outcomes on the part of the consumer of services, a fact noted by Arrow nearly forty years ago (Arrow 1963). Alternatively, institutions might develop to label/certify doctors and health care facilities, without necessarily excluding them from service provision, so as to address this problem of lack of information with the consumer (see Phelps (1997) for examples from the United States). In this case, one would naturally expect a greater demand for certified personnel and facilities and the gradual sidelining of others not so certified. This depends on the extent to which the public is capable of taking informed decisions and whether it considers the certifications credible. Finally, there could be licensure that excludes everyone other than those meeting certain standards from practicing medicine.

The contribution of an insurance scheme, whether public

²¹ The obvious culprit is the poor quality of primary care facilities, but the lack of an effective referral system is also a problem.

or private, to improving the quality of health care depends on whether the scheme is able to influence the process of labeling or licensure of medical personnel and facilities or the entry of highly skilled individuals in the health sector.

As noted previously, the provision of insurance may increase the demand for health care and so push up its price. While this would improve opportunities for high-quality individuals who might have otherwise sought employment in other sectors, it would also increase the supply of low skilled individuals into the health sector, unless appropriate screening takes place. That is, the mere increase in returns to health care provision in this sector may not increase average quality and may even reduce quality at the margin.

Insurance companies could contribute to enhancing quality if, for example, they put quality-determined restrictions on the nature of expenses they would reimburse.²² In the case of HMOs and other managed-care institutions, they could empanel only those doctors who meet certain qualification and treatment guidelines (Einthoven 1997). By enhancing the returns of such doctors over that of others they could increase the demand for such qualifications over time. The same could presumably be done for institutions such as hospitals and diagnostic centers. Moreover, by restricting the use of unnecessary expensive care through guidelines for referrals and hospital stays, managed care could also promote cost-effective treatment guidelines.

There are, however, three areas of concern. First, it is not obvious that arguments that hold for HMOs also hold for indemnity based insurance. In the case of indemnity insurance, an expansion in coverage if accompanied by an increase in demand for care induced by physicians and lack of resistance to it by private insurers and patients could lead to an enhanced use of expensive care and diagnostics without any change in health outcomes. It also does not follow that an indemnity system would cater only to highly skilled personnel and institutions. This problem cannot be readily addressed by competition if consumers of health care are unable to readily distinguish among different insurance plans and premiums charged by managed care institutions and indemnity-type insurance. It might even appear that indemnity type insurance is more consumer-friendly by not putting restrictions on whom to consult and get treated by. Even otherwise, effective competition from managed care organizations might be slow to emerge if there is resistance from associations of medical personnel, consumers and employers (for examples from the United States see Einthoven (1997)). Moreover, the formation of panels and exclusive contracting with doctors characteristic of managed care may be problematic if there are pre-existing laws against restrictive pricing practices. For instance, the GIC is exempt from the provisions of the Monopoly and Restrictive Trade

Practices (MRTP) Act (Government of India 1999h, pp. 5-8). To the extent that preferential treatment for panel doctors associated with HMOs can be interpreted as a form of restrictive trade practice, the MRTP Act would hinder the development of managed care in India, apart from giving GIC an unfair advantage in the insurance market. In these circumstances licensure and its strict implementation are clearly necessary.

Second, there is the possibility that insurers in managed care type systems sacrifice quality of care in exchange for lower costs by empanelling lower quality (and cheaper) doctors and facilities if there is a low level of quality awareness among consumers and if laws against malpractice are poorly enforced.²³ Again, this would not happen in a market where information about alternative plans and quality of care is readily available and comparable even if malpractice law was difficult to enforce. One way around this would be regulation that promotes uniform benefits' packages.

Third, if private health insurance leads to increased incomes among private providers of care, it may affect the quality of medical personnel available in public sector facilities. High returns in the private sector would lead to their exit from relatively low paying public sector jobs as well as reduce the number of new entrants into public sector jobs. There is anecdotal evidence that this is already taking place (see Naylor *et al.* 1999, pp.4, 7). Consequently, it can be expected that their departure would adversely affect the remaining users of public health facilities if replacements are unavailable.

The experience of the United States clearly suggests that HMOs provide as good if not better care than their pure indemnity counterparts whether measured in terms of client satisfaction or in health outcomes (Einthoven 1997; Phelps 1997). However, in India this would require providing information about insurance packages to consumers so as to promote more effective competition, addressing the legal issue of restrictive practices and better enforcement of standards on accreditation and laws on malpractice. In any event, it would still not address the problem of worsening quality for users of the public health care system.

Equity Implications of Private Health Insurance

Would the entry of private health insurance companies worsen the distribution of the burden of health care spending? This can happen for two main reasons. First, private insurance companies may find it profitable to undertake risk selection so as to insure low risk individuals and exclude the high risk ones from insurance.²⁴ This imposes a large burden of care on the people who are likely to get sick and most in need of risk protection. In Chile, the ISAPREs (private managed care) insure a disproportionately large number of people in the economically well off groups, leaving the worst-off to the

²²To some extent, this already exists under GIC plans. Under the Jan Arogya Scheme for instance, reimbursement for medical expenses depends on whether the medical facility used was registered with local authorities and had a qualified medical practitioner. In the sense of being registered with the appropriate provincial medical council (Rashmi Sharma, National Insurance Company of India).

²³For the generally poor state of the law on malpractice in India, see section III below.

²⁴Via exclusion conditions, tiered or durational rating (Chollet and Lewis 1997).

public insurance system (Baeza 1999). In this sense, private insurance enhances inequity unless there is access to public services of reasonable quality as a last resort. If private insurance and subsequent private care expansion attract doctors and other skilled medical personnel away from public health facilities, it would imply the worsening of quality of care available to precisely those who are denied this insurance. Second, if the entry of private insurance raises the overall costs of health care, patients who cannot afford to buy insurance (especially the poor) would have to pay larger amounts out-of-pocket.

As against this, an expansion in private insurance could lead the better off groups to consume high quality private care, thereby improving access to lower quality public sector facilities for the worse-off groups (see, for example, Besley and Coate 1991; Gertler and Sturm 1997). However, this requires the assumption that a shift out of public care by the rich will leave the magnitude of public expenditures unaffected.

It can also be argued that the burden of health care is already quite unequally distributed so that the introduction of private insurance will not make much of a difference. For instance, in their study of five Indian states, Pravin Visaria and Anil Gumber found that health expenditures as a proportion of total expenditure quintiles of the lowest expenditure quintile was typically higher than the average for all quintiles, in both rural and urban areas (World Bank 1995, p. 194). This is not surprising in a regime where more than 80 percent of all health care spending is out-of-pocket. Moreover, work by the author using the 1995-96 round of the NSS (National Sample Survey) reveals that within public facilities, the economically well off use a disproportionately large amount of inpatient care suggesting that they corner a large part of the public health spending as well (Mahal *et al.* 2000). To the extent that the poor are unable to access the best doctors/specialists in the public sector anyway, it may not make much difference to them if these medical personnel are lured away by the private sector with the entry of private insurance, political ramifications apart.

Internationally, however, the empirical evidence suggests that inequality will worsen with private insurance. A recently completed study of OECD countries found that private insurance as a means of financing health care has fairly large adverse redistributive effects across income groups in countries where it plays a major role, such as the United States and Switzerland (van Doorsaler *et al.* 1999). Moreover, simulations carried out by the author suggest that the shift effect out of the public into the private sector will be small in any event (Mahal 2000).

Health Insurance Regulation: Challenges for India

The main lessons from the theoretical and empirical literature are essentially the following: In an ideal world with well-informed consumers who can evaluate alternative health care and insurance packages with

proper legal protection and affordable care, private insurance may not be harmful for cost and quality, although its impact could still be adverse from an equity point of view. The previous section also suggests that there are specific things the government could do to yield better outcomes. These include steps to ensure financial stability of insurers, enhance consumer protection, control risk selection, promote competition among insurers, and strengthen legislation complementary to health insurance such as malpractice law and accreditation.

This section has two parts. The first focuses on regulation that relates specifically to insurance and compares the standard approach worldwide with the regulatory system in India.²⁵ The second describes existing Indian legislation regarding quality standards and consumer protection and discusses the problems faced in its enforcement.

Health Insurance Regulation: "Model" versus the situation in India

In line with the preceding discussion, we will focus on the following five topics. The last two topics relate to the regulatory agency and its powers. In each case, there is a general description of existing (or recommended) practices in other countries followed by a brief discussion of the relevant regulatory features in India.

- Financial requirements (for entry, operation, and exit);
- Consumer protection
- Risk Selection/Fairness (underwriting, rating standards)
- Benefits
- Regulatory agency: Overview

FINANCIAL STABILITY

The key issue here is to balance the requirements of financial stability with that of enhanced competition, since very strict financial standards may leave few insurers in the marketplace. Extreme competition of the "cut-throat" variety may lead to financial instability and bankruptcies (see, for example, Ranade and Ahuja 2000).

Capital and solvency requirements

Current regulatory practice is for insurers to meet minimum capital requirements *and* surplus (over liabilities) requirements known as the solvency margin. The first establishes a floor for insurers wishing to enter the market and remaining there. The second takes into account the insurer's size and risk profile. For example, the larger its estimated liabilities, the greater will be the surplus requirement. This is obviously a better indicator of the company's solvency than a system relying solely on some fixed minimum capital requirement.

In the United States, the trend is towards using a "risk-based capital standard" (RBC). The RBC formula takes consideration of possible risks from lower asset values, higher rates of morbidity and mortality, lower interest risk, and other business risks. In the European Union, the "solvency margin" is calculated as the higher of the claims

basis (23-26 percent of average claims in the last 3-7 years) or the premium basis (16-18 percent of retained premiums).²⁶ A reduction is allowed for reinsurance, up to a maximum of 50 percent of the solvency margin (EC 1999). The limit on using reinsurance for calculating solvency margins is to avoid creating incentives for the insurer to take on more risk.

The Indian regulatory structure under the IRDA Bill has similar features. Under the 1938 Insurance Act, the solvency margin (assets less liabilities) was given as a percentage of retained/net premiums (gross premiums less reinsurance payments), of the order of 20 percent (Government of India 1999d). The IRDA Bill of 1999 provides for a minimum lower bound of rupees 50 crores for the solvency margin along with a requirement of 20 percent of net premiums, or 30 percent of the average of net incurred claims in the three preceding years (Government of India 1999d, p. 28). This is in addition to an entry requirement of a minimum capital of rupees 100 crores.²⁷ In this sense, many of the provisions of the IRDA Bill parallel the regulatory features of other countries and they may become even more similar as the regulatory authority gets a sense of conditions in the insurance market over time.

As in other countries, there are a number of restrictions on the nature of investments that can be undertaken by an insurance company in India (Tapay, NAIC reference). The Insurance Act of 1938 sets these out in more detail in sections 27B and 28B (Government of India 1999d). The IRDA bill also prohibits the investment of funds outside of India (inserted as Section 27C in the Insurance Act).

Accounting and Auditing

A second condition has to do with periodic reviews of an insurer's financial condition, including audits, submission of annual reports and so on. In the United States, insurance regulators have broad powers of changing the management and financial practices should the need arise (Chollet and Lewis, p.88). Establishing and evaluating the solvency status of an insurer requires a uniform set of accounting procedures and methods by which contracts issued by an insurer can be translated into assets and liabilities.

Under the Insurance Act of 1938 and the IRDA Bill, the controller of insurance (now the Insurance Regulatory Development Authority) has wide powers just as in the United States and elsewhere. These include auditing by qualified actuaries, periodic submission of reports, appointing directors or taking over management, requesting information and even shutting down the operations of the insurance company through a court order (Government of India 1998b, 1999d).

Organizational restrictions

In many countries, insurers cannot undertake additional business that is not directly linked to insurance as, for example, banking. The main regulatory concern is that insolvency of one business may cause the insolvency of the other (Chollet and Lewis, 1997). An argument against

this restriction is that given banks, insurance companies and stock markets essentially are markets that deal with risk, an artificial separation may neither be desirable in the interests of efficiency, nor feasible (Ranade and Ahuja, 2000). Restrictions may also include specifying some desirable citizenship or residency status, ownership in the insurance company, and experience with similar business elsewhere (see also EC 1999, p.6).

Similar restrictions can be found in the Insurance Act, 1938, although not linked to any specific industry (Government of India 1999c).

Exit and Guaranty Fund

Exit rules are to ensure orderly exits from the market. The insurer who plans to leave the industry may have to give a timely notice to the regulator and submit plans for payment of all liabilities prior to the exit date. In the event of company insolvency, the practice often is that *all insurers* participate (contribute to) in the formation of a Guaranty Fund. The means of participation could be taxes on insurance premiums of the insurers. Generally, the fund does not pay out the full liabilities but only some portion of it to the insured. This is to address any problems of moral hazard on the part of insurers.

While there is an extensive discussion of liquidation of a company (voluntary or court-ordered) under the Insurance Act of 1938, there is no mention of a Guaranty Fund under Indian law. However, there appears to be some discussion about setting up a guarantee fund in the IRDA (communication with T. Raghavan, *Business Standard*).

CONSUMER PROTECTION BY THE REGULATORY AGENCY

Generally, regulation with regard to consumer protection revolves around (a) the marketing and language of insurance contracts; and (b) the relationship between insurers and providers.

Marketing and language of insurance contracts

This category covers the language of insurance contracts in a manner that it becomes easy to understand the concept along with the terms used – benefits package, premium rate, deductibles, and so on. It also includes regulations relating to unfair trade practices such as misrepresentation, discrimination, inducements, and failure to maintain records. Moreover qualifications of insurance agents and their mode of functioning may also fall in this category. Tapay (1999) documents a case where the United States government prohibited agents from specifically looking for healthy patients to enroll.

The Insurance Act of 1938 addresses directly only two concerns relating to consumer protection. It does so first by detailing the procedure by which insurance agents are licensed including the requirement that they have not been previously convicted of "...criminal breach of trust, or cheating or forgery..." or of participating in "...fraud,

²⁶Some countries use "gross" premiums to calculate solvency margins. This penalises companies that have reinsurance (Tapay 1999).

²⁷There is a 50 percent upper limit on the amount of reinsurance that can be used to calculate net premiums for calculations of the solvency margin, just as in the European Community (GOI, 1999d).

dishonesty, or misrepresentation..." (Government of India 1999d, p. 62). Second, it imposes limitations on commissions that agents can be given or the incentives they can offer to clients while selling insurance (Government of India 1999d, pp.56-60). The IRDA Bill gives authority to the regulator to specify a code of conduct for agents but no further specifics are provided. It also allows for a tariff advisory committee to oversee premium rates and insurance plans and also prevent discrimination (Government of India 1999c, p. 9).

There is also other legislation in India that addresses the issue of consumer protection more forcefully. Apart from a regulatory authority, Indian consumers also have access to consumer courts under the Consumer Protection Act of 1986, protections under contract and tort law in the Code for Civil Procedure, and the Arbitration and Conciliation Act of 1996. These are discussed further below.

Relationship between insurers and providers

The aim is to ensure that health care providers remain professionally independent of the providers in a managed care system. In its absence, providers may be under pressure not to recommend expensive treatments. In the United States, regulations permit any provider to join a plan if he or she accepts its payment conditions. Similarly, they allow providers to work with patients outside their plan (the provider cannot be locked in by the HMO or other form of managed care organization).

Unfortunately, consumer protection laws in India have little to say on the relationship between the insurer and the provider. It may be that some of the practices described above could potentially fall into some version of "unfair trade practices" which belong in the realm of the MRTP (Monopoly and Restrictive Trade Practices) Act (Government of India 1999h). At the present time, there is no case law to support or dispute this assertion. The bulk of the existing case law deals with fraudulent claims or delays in clearing claims by the insurer (see, for example, Aggarwal and Chaudhri 1998).

RISK SELECTION/FAIRNESS

Regulation in this area has taken two main forms in the United States: (a) restriction of underwriting/risk selection; and (b) restriction on prices based on health status.

Underwriting restrictions

These restrictions may involve a *guaranteed issue* of certain plans (or all plans) to all applicants, without regard to their risk profile. A variation on this may be *guaranteed renewal* where the insurer can underwrite applicants at the time of first issue but not on subsequent renewals. In case only a few select plans are subject to this restriction, these plans will become much more expensive if the risk composition of the plan determines its price. Of course, if all plans were subject to this restriction there would be the problem of adverse selection. Ways to get around this would be the exclusion of "pre-existing" conditions, or

having open enrollment only at certain times of the year.

A variation of the restrictions noted in the previous paragraph is the *portability requirement*. These are often used along with pre-existing exclusion restrictions. For example, as long as a reasonable continuity is maintained in coverage, a second insurer cannot impose a pre-existing exclusion on a person who has already exhausted a similar exclusion with another insurer. Other restrictions could relate to insurer requests for medical history, application forms for insurance coverage, and so on.

Community rating and rate review

Community rating is the requirement that premiums be based on some broad geographic or demographic criterion rather than on individual health status. This is likely to be somewhat inefficient since it involves a degree of cross-subsidy across participants.

Another approach to this is controlling the premium rates directly by requiring government approval for rate levels and increases. The normal method to do this is by examining "loss ratios" – the proportion of claims to premium income — and putting a bound on them.²⁸

By restricting risk selection, the expectation is that insurers will compete in quality and prices. However, this may be particularly problematic in countries newly opened to the private insurance sector, as problems of adverse selection could overwhelm the small number of companies who first enter the market. As in the previous section, there is currently no legislation in India that has specifics on underwriting restrictions. However, a tariff advisory committee and the IRDA have the power to issue guidelines relating to non-discrimination and the "...control and regulation of rates, advantages, terms and conditions..." (Government of India 1999c, p. 9; Government of India 1999d).

BENEFITS

There are two issues of interest with regard to benefit packages : (a) a minimum package of services available to everyone, and (b) catastrophic insurance.

Uniform minimum benefits package

Given a uniform minimum benefits package that is accessible to all applicants, insurance companies would have a tendency to offer additional products to appeal to low risk applicants, or indulge in underwriting. Both options would increase costs and promote inequity – the latter by way of higher administration costs as well as increased premiums for the relatively more sick, and the former in terms of higher premiums for the sick which increase difficulty in choosing among options on account of greater variety. Thus, it would seem that the regulation on benefits packages ought to accompany some sort of market "managing" regulation in the sense of Einthoven (1997) or Medici et al. (1997) that creates large buyers in the insurance market. The presence of large buyers could help enforce rules among insurers in exchange for the volume of business they can bring. Examples of this are

²⁸A number of state in the U.S. have loss-ratio restrictions (Chollet and Lewis 1997).

the social insurance schemes of the type in Netherlands and Israel (Chinitz 1995; West 1997; Ham 1997). In each case, a (uniform) basic package of services is provided by a set of sickness funds with compulsory enrollment in at least one of them. Funds from a central source follow the individual and there is some risk-adjusted capitation payment to curtail risk selection. As a consequence, there is an increased likelihood of competition in quality and less of risk selection.

Catastrophic insurance and emergency care

These can only be covered through reinsurance of various kinds in view of the rarity with which they occur. Unfortunately, in developing countries, private reinsurance is typically difficult to obtain because of the poor quality of actuarial data on rare events (Chollet and Lewis 1997, p.94). Reinsurance could be promoted in the form of more relaxed solvency margin requirements as in the European Community.

There is no legislation in India relating to benefits packages of either type. The only pertinent statement is in the Insurance Act of 1938 stating that the Tariff Advisory Committee (and the Insurance Regulatory and Development Authority under the IRDA Bill) will oversee rates, benefits and other activities of insurers. The IRDA Bill, however, does allow not only the entry of re-insurers in the Indian insurance market but also relaxes solvency margin requirements (Government of India 1999c).

REGULATORY AUTHORITY: OVERVIEW

There are two issues of relevance here – (a) What are the main functions of this authority? And who does what? (b) How will the authority be funded?

Main functions

The two main functions relate to market standards (including consumer protection) and to overseeing solvency and financial regulation. In the United States, the states have the primary responsibility for regulating insurance, including solvency and financial standards. In the European Union, supervisors in each country enforce country-specific market standards, but the financial standards are similar for all EU countries (Tapay 1997).

Funding

Funding could be obtained from sources such as a premium tax (about 2 percent of annual premiums in the United States), allocation from general funds to the insurance department, and a “dedicated funding system” whereby fees, fines and other income generated by it are placed in a separate fund.²⁹

Unlike the previous two sections, the Insurance Act of 1938 and the IRDA Bill of 1999 have much to say on the nature and functions of the regulatory authority. In some cases, the authority is wielded directly by the so-called “controller of insurance” or the IRDA. In other cases, it is committees predominantly composed of insurers and headed by the controller (for details see Government of India (1999c,d). As per the Indian Constitution, the authority

to regulate insurance is centralized in the IRDA and the central government with little control by Indian states.³⁰ The IRDA has the authority to levy fees or other charges to carry out its functions and can have access to grants from the central government.

Summary Remarks

The general picture that emerges is that legislation (existing and proposed) concerning health insurance in India is fairly comprehensive even in comparison to a model set of regulations when focusing on auditing, financial controls, investment guidelines and licensing regulations. There is much less focus, however, on the demand side of the market – especially the consumer of insurance products. To be sure, both the Insurance Act of 1938 and the IRDA Bill are sufficiently comprehensive (ambiguous!) to allow increased focus on consumer interests, yet problems remain. Discussions about managing the demand side of the market invariably have implications for revamping CGHS and ESIS, the latter being directly related to an Act of Parliament over which IRDA has no authority. Regulating the relationships between insurers and providers or controlling rates would have implications under the MRTP Act and that too is included in parliamentary legislation.

The IRDA has little or no authority over various types of legislation that relate to quality of health inputs and it is to that we now turn.

Other Legislation Relevant to Health Insurance in India

The discussion of the previous two sections points to the importance of the following types of legislation for health insurance to function properly:

- Consumer protection (including malpractice law);
- Quality of medical personnel;
- Quality of health infrastructure.

Table 4 summarizes some of the major features of law related to consumer protection in India. The two most common avenues for relief in the arena of medical care are the Consumer Protection Act and various civil courts (see, for example, Reddy 1997). Unfortunately, the experience with the Indian court system is not very positive which, by all accounts, is characterized by lengthy delays, problems with procedural law and a massive backlog of cases. According to one estimate it would take nearly 324 years to clear the existing backlog! (Debroy 1999).

Given these problems, it is not surprising that the various consumer commissions established under the Consumer Protection Act (COPRA) of 1986 have begun playing a key role in protecting consumer rights, in spite of their relatively recent origin. The main rationale for COPRA was that it could offer a quicker and cheaper way for consumers to address their grievances. Certainly, a number of cases related to insurance and medical negligence have reached these courts (Aggarwal and Chaudhri 1998; Vats 1997). Unfortunately, recent evidence suggests that problems with

²⁹In 1997, premium volume in life and health insurance was US\$340 billion.

³⁰Items 43 and 47 (Union list) of Schedule VII of the Indian Constitution (Government of India 1996).

backlogs have begun to occur in consumer courts as well, due to an inadequacy of "judges" and to the increase in the burden of cases (Bhat 1996). These courts also face a problem of adequately addressing malpractice suits against doctors. The problem has arisen because doctors are unwilling to depose against their peers and the poor record of medical councils in this respect.

This last point highlights the failure of medical councils of practitioners at the national and state levels to self-regulate. Indeed, there is clear evidence of foot-dragging by doctors in cases that involve malpractice suits against their colleagues (Jesani, Singhi and Prakash 1997).

Table 5 presents legislation related to the maintenance of quality standards in the health sector – whether for medical facilities, or for medical personnel. There is some legislation that seeks to maintain quality among medical personnel (including practitioners of traditional medicine) at various levels – both at the central and provincial levels. Typically, this legislation involves the setting up of bodies (or councils) that oversee the maintenance of quality in new entrants to the profession, maintenance of membership records of the profession and, through codes of conduct and sanctions, maintenance of standards among existing members. Although these councils are widespread and cover various states, the record of these councils in ensuring continued good behavior is quite poor (Jesani, Singhi and Prakash 1997). Moreover, there is evidence of practitioners of traditional systems practising modern allopathic medicine without any sanctions.

The problem with quality control is somewhat worse in the case of health infrastructure. Until recently, the only relevant legislation was the Nursing Home Registration Act, in a small group of states – Delhi, Maharashtra and Bengal (Nandraj, Khot and Menon 1999).³¹ The focus of these laws is primarily on registration of facilities, although the Delhi legislation specifies quality standards for these facilities (Nabhi Publications 2000, p. 12). In any event, the enforcement of even these laws has been poor – records of private facilities are generally incomplete and the few existing studies typically find substandard facilities, understaffing and generally low quality of care provision. There was no law with respect to diagnostic centers until recently (in fact, the Delhi Shops and Establishments act specifically excludes medical facilities (Nabhi Publications 2000)). Now however, the proposed Delhi Private Medical Establishments "Act" (Aggarwal and Chaudhri 1998) also seeks to impose quality standards on diagnostic centers. Moreover, the Environment Act (1986) may have implications for X-ray centers by setting conditions on polluting emission of radioactive particles (Government of India 1999i, p. 79).³²

Concluding Remarks

There are three main conclusions with regard to issues specific to insurance. First, the impact of the entry of private health insurance could have adverse implications for some of the goals of health policy. However, a competitive health

insurance market, less risk selection and an informed insurance regulation are likely to lead to better social outcomes. Second, there are clear areas where regulation with regard to health insurance could be useful – in instituting benefit packages, restrictions on risk-selection procedures, and some aspects of consumer protection. Third, there are areas where the work of the IRDA would require coordination with other central institutions such as the MRTTP Commission.

Addressing these issues requires meeting some challenges. The first and most compelling one is based on the observation that in a regime with poor enforcement, this would simply complicate the picture without yielding any direct benefits. Even COPRA (Consumer Protection Act of 1986) that was meant to address the rights of consumers through the establishment of special consumer courts has suffered from delays of various kinds (Bhat 1996a, Hindu 1999). *There is, therefore, no reason a priori to expect that health insurance regulation enforcement would do any better. It might be argued that as an independent regulator, the Insurance Regulatory and Development Authority (IRDA) would have much greater leeway in implementing its own guidelines. However, the recent experience of another such institution in the telecommunications sector (Telecommunications Regulatory Authority of India (TRAI)) suggests that this is, by no means, certain.*

Second, it is also the case that some of the regulatory changes envisaged in health insurance also appear to require more fundamental changes in the existing publicly financed and provided care. In particular, for uniform benefit packages to work and for competition among insurance companies, large buyer groups may have to be created on the pattern of the United States and various European countries. One interesting possibility is revamping the CGHS (Central Government Health Scheme) and ESIS (Employees State Insurance Scheme) to divest them of their provision function. But these could imply large legislative shocks to the existing system and meet strong political resistance. On the other hand, it may be that the actual costs are not as high as the perceived costs – they might well be small if one considers the general lack of satisfaction with CGHS and ESIS facilities.

Third, there is the issue of the size of the private health insurance market in equilibrium. One rough estimate by the author is of the order of 3,000 to 4,000 crores of rupees in terms of annual premium income (Mahal 2000). Even at thirty to forty times its current size, it is still quite small at 6 percent of existing levels of private health spending. This suggests that the gains (or losses) from the introduction from private health insurance are likely to be small in the aggregate. So any additional legislation to influence the private health insurance market could simply incur low costs for low return in the short-run. Again the long-term implications ought to be clear. Once a system is in place, it acquires an inertia of its own as in the case of resistance put up by provider associations during the efforts

³¹More recently, some states have begun taking steps to introduce fresh laws regarding private establishments (Aggarwal and Chaudhri 1998; Nandraj, Khot and Duggal 1999).

³²There is also legislation on pre-natal diagnostic techniques (see Aggarwal and Chaudhri 1998).

to expand the coverage of managed care organizations in the United States (Einthoven 1997).

Where legislation on quality standards in health care provision is concerned, the IRDA faces an even greater challenge since many of the laws and their implementation are in the hands of individual states as

constitutional requirement. Moreover, all evidence indicates that these are incomplete in scope, poorly designed, and hardly ever implemented. This makes the design of insurance policy more difficult and suggests taking a comprehensive and long-term look at issues of health insurance and care provision in India.

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TABLE 1. CHARACTERISTICS OF TWO PUBLIC INSURANCE SCHEMES

Type of Insurance	Contribution	Reimbursement	Entitlements	Eligibility												
ESIS (Employees State Insurance Scheme)	Employees: 4.75% of wages Employers: 1.75% of wages All contributions are deposited by the employer; State governments contribute a minimum of 12.5 percent on ESIS health expenditure in their respective states (Garg 1999b, p.30). See also section 59A (Government of India 1999g, pp. 51-52).	Does not disallow reimbursement of medical treatment <i>outside of allotted facilities</i> . For instance, the Employees State Insurance Act, 1948 states that entitlement to medical benefits does not entitle insured to "claim reimbursement for medical treatments... except under regulations." (Government of India 1999g, p. 50). See also Chapter III, 28(v) and ESI (General) Regulations, 1950 (Government of India 1999g, p. 156).	Depending on "allotment" as per the ESI Act 1. Outpatient medical care at dispensaries or panel clinics; 2. Consultation with specialist and supply of special medicines and tests in addition to outpatient care; 3. Hospitalization, specialists, drugs and special diet. 4. Cash benefits: Periodical payments to any insured person in case of sickness, pregnancy, disablement or death resulting from an employment injury.	Employees (and dependants) working in establishments employing ten or more persons (with power) or twenty or more persons (without power) and earning less than Rs 6,500 per month (Garg 1999a, p. 85).												
CGHS (Central Government Health Scheme)	<table><tr><td>Pay/pension (Rs/month)</td><td>Contribution (Rs/month)</td></tr><tr><td>< 3,000</td><td>15</td></tr><tr><td>3,001-6,000</td><td>40</td></tr><tr><td>6,001-10,000</td><td>70</td></tr><tr><td>10,001-15,000</td><td>100</td></tr><tr><td>> 15,000</td><td>150</td></tr></table> <p>The bulk of the resources (85 percent) come from general revenues of the central government (Garg 1999b, p.34)</p>	Pay/pension (Rs/month)	Contribution (Rs/month)	< 3,000	15	3,001-6,000	40	6,001-10,000	70	10,001-15,000	100	> 15,000	150	<ol style="list-style-type: none">1. Reimbursement of consultation fee for up to four consultations in a total spell of ten days (on referral).2. Cost of medicines;3. Charges for a maximum of ten injections;4. Reimbursement for specified diseases/ailments	<ol style="list-style-type: none">1. First level consultation and preventive health care services through dispensaries and hospitals under the scheme;2. Consultation at a CGHS dispensary/polyclinic, or CGHS wing at a recognized hospital;3. Treatment from specialist through referral, emergency treatment in private hospitals and outside India.	Employees of the central government (excepting Railways, Armed forces pensioners and Delhi Admn.), pensioners, widows of central government employees, Delhi Police employees, Defence employees and dependants residing in 24 specified locations (see Government of India, Various)
Pay/pension (Rs/month)	Contribution (Rs/month)															
< 3,000	15															
3,001-6,000	40															
6,001-10,000	70															
10,001-15,000	100															
> 15,000	150															

TABLE 2. ADMINISTRATIVE COSTS OF OPERATING HEALTH INSURANCE PROGRAMS: A COMPARISON OF PRIVATE AND PUBLIC INSURERS

Country	Costs of administering insurance (as percent of expenditures)	
	Private	Public
Chile	18.5	1.8
Sweden	n.a.	1.5-5.0
United Kingdom	n.a.	10.0 (GP Fundholdings)
United States	5.5-40.0	2.1 (Medicare)
India	20.0-32.0	5.0-14.6

Notes: For the United States, the range in the private sector reflects low costs for group insurance to high costs for individual insurance; for India the range in the private insurance represents the different experiences of the four subsidiaries of the General Insurance Corporation (GIC); for the public sector insurance in India the lower bound for the range are the costs of CGHS and the upper bound for ESIS (Garg 1999); for Sweden, the range reflects public schemes operating in City Councils and among those relating to private doctors; GP = General Practitioner.

Sources: Chile (Baeza 1998, Ferreiro 1999); India (Garg 1999; communication with Anurag Kaul (New India Assurance Company)); Sweden (Rehnberg 1997); United States (Rehnberg 1997); United Kingdom (West 1997).

TABLE 3: HEALTH SPENDING PER CAPITA AND PRIVATE INSURANCE COVERAGE: Cross-country regressions

Regressors	Dependent Variable; Log health spending per capita(US\$)			
	(1)	(2)	(3)	(4)
Constant	3.86 (0.35)	-5.02 (0.48)	-4.83 (0.48)	-4.83 (0.46)
Private health insurance Coverage (% of population)	0.08 (0.01)		0.007 (0.004)	0.007 (0.005)
Log of per capita income (US\$)		1.27 (0.06)	1.24 (0.06)	1.23 (0.06)
Dummy for type of private health insurance				-0.005 (0.180)
Sample size	31	31	31	31
R-squared	0.42	0.93	0.94	0.94

Notes: Robust standard errors reported in parentheses.

Type of private insurance: 1 for countries where private insurance is offered as an alternative to social insurance or public scheme; 0 for countries where private health insurance can only be offered as a supplement to a public insurance scheme.

Countries included in sample: Australia, Germany, Ireland, Netherlands, United Kingdom, United States

(OECD); Argentina, Brazil, Chile, Colombia, Dominican Republic, Ecuador, Guatemala, Jamaica, Honduras, Mexico, Peru, Uruguay (Latin America and the Caribbean); Ivory Coast, Egypt, Jordan, Kenya, South Africa, Zimbabwe (Africa and the Middle East); India, Indonesia, Philippines, Sri Lanka, Thailand (Asia); and the Czech Republic.

Sources of Data: Chollet and Lewis (1997); World Bank (1997).

TABLE 4. SELECTED LIST OF LEGISLATION/RULES LINKED TO CONSUMER PROTECTION IN INDIA

Legislat	Objective	Powers/Functions/ Procedure	Monitoring/Implementing Authority
Consumer Protection Act, 1986	To protect consumer rights such as: 1. Protection from marketing of services hazardous to life 2. Right to be informed about quality, quantity, standard, price and purity for protection against unfair trade practices 3. Seek redressal against Unfair trade practices or Exploitation of consumers	A complaint under the Act can be made when there is a deficiency in services – any fault, shortcoming, inadequacy in quality of medical or insurance services, or if an excessively high price is being charged. To observe principles of natural justice and to award appropriately, compensation to consumers.	Central and State Consumer Councils 'promote' various objectives related to consumer rights District, State and National Consumer Commissions function as quasi- judicial forums to address consumer complaints. Orders of the National Commission can be appealed only in the Supreme Court.
MRTP Act, 1969	Prevention of concentration of economic power, control of monopolies and prohibition of monopolistic and restrictive trade practices	Conduct inquiries into monopolistic and restrictive trade practices based on complaints by the government, own information, or a consumer, or an association or consumers or traders. Can award compensation for any loss or damage resulting from unfair trade practice.	Monopolies and Restrictive Trade Practices Commission.
Employees' State Insurance Act, 1948 (Section)	Address consumer (and other) complaints	Complaints about treatment received; benefits not received; eligibility, etc.	Medical Benefit Council Medical Appeal Tribunal Employees' Insurance Court

CGHS Rules	Address consumer (and other) complaints	Complaints about treatment received, benefits not received, eligibility, etc.	Internal dispute resolution mechanism
Arbitration and Act, Conciliation 1996	Address Consumer (and other complaints) generally, but also GIC specifically	All complaints and demands for compensation	Arbitration Tribunal
Indian Contract Act 1872; Code of Civil (Criminal Procedure)	Consumer complaints	For breach of contract, deficiency in services, damages, dispute of facts, negligence and so on	Judicial system/Courts
Drugs (Control) Act, 1950	Control over sale and price of drugs	Fix maximum prices and maximum quantities that may be sold General limitations on the quantity that may be possessed at any one time	Chief Commissioner Drug Controller of India
Indian Medical Council Act, 1956	Defining a professional code of conduct	Taking doctors off the registry roles for violation of rules of conduct	State medical council Medical council of India

Sources:

Aggarwal and Chaudhri (1998); Reddy (1997); Government of India (1999c); Bhat (1996).

TABLE 5. LEGISLATION RELATED TO STANDARDS IN THE HEALTH SECTOR

Legislation	Objective	Powers and Functions	Quality Controls	Implementing/ Monitoring Authority
The Bureau of Indian Standards Act, 1986	Provide for the establishment of a Bureau for the harmonious development of activities of standardisation, marking and quality certification of goods	Co-ordinate activities of any manufacturer or association or consumer(s) engaged in standardisation and improvement of quality Grant, renew, suspend, or cancel licenses for use of standard mark. Inspect samples, establish laboratories for standardisation and quality control Address consumer complaints about quality of a product	Establish and publish Indian standards in relation to any article or process Specify a standard mark to be called the "Bureau of Indian Standards Certification Mark"	Bureau of Indian Standards
Drugs and Cosmetics Act, 1986	Quality control of drugs	Power to deem a drug misbranded, adulterated, spurious and to prohibit adulterated, misbranded and spurious drugs import, manufacture and sale of certain drugs	Define standards of quality, adulterated, misbranded and spurious drugs	Inspectors for this purpose appointed by central and state governments
Nursing Home Registration Acts (Delhi, Maharashtra, Bengal)	Registration of private hospitals	Maintain a register of private hospitals; may enter and inspect a nursing home; inspect any records; cancel registration if not meeting the provisions of the Act.	None specified	Municipal Authority/ State Government
Indian Medical Council Act/Nursing Council Act, 1947/ Pharmacy Act 1948/ Indian Medical Degrees Act 1916) and various.	Create minimum and uniform quality standards	Various Councils (Medical, Nursing, Pharmacy, Dental, Indian Systems): Give recognition to institutions that train medical personnel; maintain uniform standards; maintain registry; define a professional code of conduct for doctors; take doctors off the rolls for violation of code of ethics	May prescribe standard curricula for training of medical personnel; conditions for admission; examination standards	Indian Medical association: Medical/Nursing/Pharmacy Councils of India and respective State Councils.

Sources: Sunil Nandral (personal communication); Aggarwal and Chaudhri (1998); Government of India (various).

PRIVATE HEALTH INSURANCE IN INDIA: WOULD ITS IMPLEMENTATION AFFECT THE POOR?

On November 16 and 17, 1999, a specialized seminar was held in Delhi with regard to the introduction of private health insurance, its potential impact for both those who would be able to buy a health insurance policy and the vast majority of the population who certainly would stay out of the new scheme. A discussion on the proper regulation of private health insurance was also addressed. Further discussions with emphasis on field experience followed.

Summary

Before considering the nature and prospects of an adequate regulatory framework for private health insurance, a basic and fundamental question about the final objectives of the Minister of Health (MoH) intervention in the current process ought to be answered. Who are the subjects or potential beneficiaries of the MoH concern? Are both sectors – the 3 to 5 percent of the better off population as well as the remaining 95 percent of Indians – within the scope of official concern?

Depending on these considerations, recommendations should either vary or be adjusted. In effect, if private policyholders are to be protected from the most common shortcomings, failures and potential abuses that occur due to unregulated private health insurance, there are very specific suggestions that can be presented for the building of a comprehensive regulatory framework. However, some of the suggestions are both ineffective and unnecessary when dealing with a voluntary/supplementary type of health insurance.

It is a fact that those who can afford a private health insurance are not the priority of public regulation. This argument is based not only in the fact that the wealthy population can look after its own rights and expectations, but also on the very nature of a voluntary scheme. If the customer/insured does not feel he/she is getting real value (financial protection and/or fluid access to good health care) for money, he/she would just refuse to buy a policy or would move from one firm to another. In a voluntary scheme, like the one which is under consideration in India, market competition will certainly control and counteract any shortcoming of the insurer. This can be ensured to the extent that relevant and reliable information is made available for a well-informed client decision making process.

The answer to the preceding question might be, on the contrary, that only the poor should constitute the government concern. If it were so, the analysis should focus on how the poor could avail some of the potential benefits that are expected to result from the introduction of private health insurance in the country. If this is impossible or

irrelevant, public policy should aim to prevent any undesirable negative effect on the needy population at the least.

Approach to a Regulatory Framework

Two approaches can be observed when dealing with the issue of when regulation should be introduced. A "wait and see" attitude to regulating health insurance may prove to be a high-risk decision, as other countries' experiences can demonstrate (Chile, USA). From a strictly technical perspective, it is always better to regulate after monitoring and evaluating concrete problems. However, it should be borne in mind that late regulation tends to become impossible to get approved, due to the preventive and obstructing lobbying capacity exercised by those players who take advantage of the prevalent situation.

A "do it now" approach would probably emerge as the only responsible and feasible alternative, for regulation might be acceptable as an "entrance fee" for the same that would reject it afterwards.

Therefore, a preemptive strategy, aiming to protect both the poor from a further worsening of their access to health care and the privately insured should be considered.

Can the poor benefit from the introduction of private health insurance?

Unfortunately, a clear-cut answer does not seem to be available at this point. Although some suggest that the migration of the better-off to a private scheme would ease the currently overloaded public facilities in favor of the poor, the available data regarding the high ratio of private expenditure and the growing importance of private providers tend to prove that the migration of the majority of the population already occurred some years ago. Therefore, a social gain in this regard seems unlikely.

The poor might benefit from the expansion of private providers if the supply of health care expands due to an increase in health care affordability resulting from health insurance. However, if prices grow faster than delivery capacity, cost escalation may even expand the existing gap between the poor and the required access to health care. All this is highly unpredictable, since it depends on the supply of health care and the prevalent model of health insurance to be implemented. Regarding the latter, it is clear that an indemnity/fee-for-service system will unavoidably result in a severe cost escalation whereas a managed care oriented type of insurance would probably be capable of maintaining costs under control.¹

In the long term, however, the entire population might benefit from the introduction by the international health

¹Some concern has arisen in relation to the possibility that some versions of managed care could be found illegal under current Indian anti-monopoly regulations. In fact, even charity hospitals employing some kind of pre-payment mechanism are under scrutiny. If that legal constraint becomes a real obstacle for the expansion of managed care oriented health insurance, the indemnity model will prevail, resulting both in cost escalation and in a significant reduction of the potential market for private insurance.

insurance companies of the medicine based on evidence approach, concretely represented by standards, protocol guidelines for treatment, cost-effectiveness and clinical data analysis. Indeed, the latter should be expected if managed care be allowed to pursue the strategic goal of expanding the prospects of health insurance market shares beyond the few who can afford an indemnity policy. Since managed care inherently entails some integration between the payer and the provider and can ensure the monitoring of the type and quality of the health care provided, this market driven effort towards quality assurance might be considered as a likely positive side effect of private health insurance in India.

How to prevent negative side effects for the poor resulting from the introduction of private health insurance.

The impact of private health insurance on the wealthy and its effects especially over the poor is not yet clear. While the migration of doctors and health care staff to the private sector occurred some time ago, the impact of prices on the poor is not clear, particularly because it is uncertain that this will occur within the scope of the health care that the poor already have access to.

Nonetheless, some direct action can be taken to prevent public subsidies to private health insurance, since that is second method by which the poor can be negatively affected by private health insurance.

In this regard, the following recommendations should be borne in mind:

- Private funding to support a specialized regulatory agency. Unless the indemnity model is envisioned as the exclusive type of health insurance, a specialized regulatory method is needed to deal with the health care specifications of health insurance. Allocating public budget to that purpose contradicts equity oriented public policies for it would result in an undesired public subsidy for the better off. Therefore, the resources needed to fund the private health insurance regulatory agency should be extracted from premiums. A more detailed calculation is needed with regard to the fixed amount or percentage to be charged of every policy.
- Conflict resolution proceedings must be part of specialized regulatory agency duties. Otherwise, if subscribers have to present their claims to a regular tribunal, a public subsidy will be rendered. Additionally, the complainant may find the exercise worthless in relation to litigation expenses.
- User fees ought to be charged to the privately insured when they avail health care services from a public facility. Those who prove to have the payment capacity to buy a private health insurance should pay the full rate (real cost of delivery, including investment provisions) of the health care given by a public provider. Although most subscribers may prefer to access a private facility, international evidence shows that many private health plans establish limited coverage for high cost

treatments (catastrophic diseases, for instance) forcing their insured to resort to a public hospital to get a low price treatment. This risk is inherent if some good quality public hospitals exist. Therefore, this possibility must be taken seriously to prevent another form of undesired cross subsidy.

PROTECTING THE SUBSCRIBERS OF PRIVATE HEALTH INSURANCE: A BASIC, USEFUL AND FEASIBLE REGULATION FOR A VOLUNTARY TYPE OF PRIVATE HEALTH INSURANCE

Two basic considerations frame the following analysis:

- Some problems seem unavoidable in the functioning of voluntary private health insurance. Among these, the most salient is risk rating, and its inherent negative effect upon those whose actuarial health risk ranks higher than their payment capacity – the elderly, large families, infants, and women during fertility age if maternity care is included in the package of benefits. A risk equalization scheme needs mandatory enrollment to be implemented. Otherwise, cross subsidization becomes impossible and those who intend to pay more than their actuarial risk would obviously be unwilling to do so. Therefore, risk selection against the poor and the risky would be the inescapable consequence of pricing policies under a voluntary scheme. For various reasons, regulators can do little to control underwriting or the denial of coverage regarding pre-existing conditions. Indeed, by doing so, a subsidy from the healthy towards the already sick appears, since whenever an insurer is forced to pay for preexisting conditions in a way that would promote adverse selection, that financial load is translated to the portfolio's premiums. Moreover, in such a situation, adverse selection would even reach levels that challenge the financial sustainability of the whole system. In sum, under a voluntary supplementary system like the one which is currently envisioned in India, a cautious approach with regard to these kind of regulations is to be suggested. The same can be said in relation to fixing prices, since it has been demonstrated that health expenditures are almost impossible to predict over a long term, particularly under an indemnity/fee-for-service model. As we see in the following lines, market competition when provided, can be more efficient in regulating prices.

Customer (insured) can and should vote with their feet

Under a voluntary scheme, people would join a private insurance only if they feel it is worthy. If a player can't approve the "value for money" test, its actual or potential customers will punish the player either by quitting or neglecting the scheme. This market driven self-control mechanism is bound to work efficiently if some basic preconditions are provided.

Information: Comparative, reliable and comprehensive

information should be given to the public. Otherwise, blind decisions may shadow the interaction between the insurer and insured. When dealing with managed care, information should include references to the quality of care delivered by the preferred provider. Rankings elaborated and published by the regulatory agency may help in promoting competition based on real quality and efficiency.

Mobility: Unless subscribers are entitled to move without major restrictions from one health insurance company to another, the coexistence of several insurers would not result in real quality oriented competition. Therefore, some regulations are to be implemented to guarantee mobility among the insured².

This is not to deny the importance of regulation. On the contrary, regulation is certainly needed, though its final impact depends, not only on the enforcement capacity of the regulatory agency, but to a great extent on the ability to limit the focus of the regulatory tools to what is reasonably achievable. Finally, regulators should regard self regulation by market forces as a partner that needs to be nourished through information and transparency.

It is recommended that the following basic regulations/steps be considered:

Having underlined the importance of self-regulation within a voluntary health insurance system, a brief review of basic regulations is needed. In this regard, some fundamental rules of the game must be noted.

- o Uniform minimum benefits package. This is needed not only to make comparison between competitors possible,

but also to assure some compatibility between sanitary priorities and the service provided. The package might include catastrophic disease and emergency care.

- o Renewal of contracts must be guaranteed. The risk is to be placed in the insurer, for that is what insurance is all about. If the insurer is allowed to cancel a policy or to adjust its conditions (prices and/or benefits) according to the insured medical record, private health insurance would result in social fraud. Therefore, whereas the insured need to enjoy freedom to exit the contractual relationship, that must not be available for insurers.
- o Consumer redressal mechanism. It should be simple and inexpensive for the insured. It should also be fair, specialized and work most smoothly. In addition, conflict resolution schemes should be entitled with the right to punish illegitimate denials of claims on the part of the insurer.
- o Regulating marketing and language of insurance contracts.

The regulatory agency must set some uniform and clear instructions with regard to the design, order, and language of contracts. This is crucial to strengthen the consumer's ability to understand, compare, and choose on the basis of adequate information and a well-formed opinion. Accordingly, unfair but common trade practices such as misleading, misrepresentation, inducements, and falsifications of the subscriber signature ought to be severely forbidden and punished.

²Nonetheless, some reasonable length of stay with the elected insurer is to be mandated-1 to 2 years. Otherwise, an extreme mobility would generate adverse selection, while paving the way for an excessive cost in agents' fees and advertising.

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CONCLUSIONS OF THE NATIONAL SEMINAR ON HEALTH INSURANCE

On November 16-17, 1999, a meeting was held in New Delhi to identify actions to be taken by the Government of India (GOI) to deal with the pending introduction of private health insurance, which is a part of the Insurance Regulatory and Development Authority (IRDA) Bill currently before Parliament. This note summarizes the main findings and recommendations.

Health Insurance Objectives

The underlying assumption is that government's interests are to assure that appropriate health care is affordable and available to all its citizens, and to the poor in particular. The liberalization of private health insurance must not be seen in isolation of other health reforms needed to improve access, quality, and affordability of health services, and improving health outcomes.

In designing the IRDA Bill, the liberalization of insurance was expected to have a minor influence on the health system. Private insurance was viewed as a source of supplementary insurance for better off sections of society and those in the organized sector who could afford it (perhaps up to 3-5 percent of the population), whereas basic health service needs would be covered by the state. However, the vast majority of health spending and health delivery is already occurring in the private sector in India, including among the poor. Health insurance must be examined in the context of what efforts India can make to better the use of the large amount of private financing and delivery of health. One significant risk of insurance liberalization is that it could further drain resources away from the poor.

Key Health Insurance Considerations

Key questions considered at the meeting were:

- How can health insurance improve efficiency and equity in the health sector? What else is needed?
- How can government prevent any unwanted damage to the health system that may result from the introduction of private health insurance?

Fee-for-service payments to providers, based on indemnity insurance, is the main type of insurance expected in an unregulated market in India. This has led to unbearable cost escalations in health care in countries where this type of private health insurance has been introduced. The likely effect is to increase the gap between the price of health care and those who are able to afford care, leading to greater overall health care costs and larger inequities. The GOI should take measures to prevent this from occurring.

A "wait and see" attitude to regulating health insurance is a high risk approach – other countries have found it nearly impossible to change the rules for insurers or providers once there are established interests. Whether it

is important to deal with this risk in part depends on how large the private insurance market becomes in India. If only a small portion of the wealthiest segments of Indian society are engaged in private health insurance, the risks posed to social goals are less problematic. The alternative approach is to establish appropriate regulations at the point of introduction of private health insurance, to ensure a more transparent, fair, and efficient health insurance market.

Voluntary health insurance inevitably leads to risk ratings of premiums, which has discriminative effects on the sick, the elderly, women, large families, and the poor in general. There are some ways to reduce these effects through regulation, but short of mandatory insurance systems with built-in risk equalization schemes, they are imperfect. GOI is not yet prepared to reform and expand mandatory health insurance systems, so other mechanisms must be introduced to mitigate these effects.

Specific Recommendations

Two types of recommendations are made, including those designed to: 1. Directly protect the interests of the poor; and 2. Make private health insurance operate better for subscribers and contribute to the overall health system, with the view that one day larger portions of the population may benefit from health insurance mechanisms.

Pro-Poor Recommendations

- Public subsidies to the wealthy should be reduced or eliminated, including those that are introduced through private health insurance. Such measures would include:
- Charge full cost recovery in public hospitals to people who have private health insurance.
- Ensure that the agency responsible for regulating health insurers is financed through premiums, rather than through general taxes, at say 0.5 percent of the premium cost (a special health insurance regulatory agency is proposed – see below).
- Reduce or eliminate tax incentives for private insurance, particularly indemnity-based insurance which is more likely to escalate health care costs.
- Define a minimum package of benefits for all insurance packages, including key preventive and maternity services.
- Ensure that there are no barriers to managed care through not-for-profit (trust) hospitals or non-profit networks. Similarly, community financing schemes for the poor and non-formal sector, such as those established by cooperatives, associations, or other non-profit organizations, should be encouraged. A Rs. 100 crore capital requirement for health insurance proposed in the IRDA Bill should not apply to these schemes. Rather, a guarantee, such as one month's worth of

premiums could be kept on deposit by the regulator. Government should provide or obtain financial and technical assistance for experiments designed to provide pooling of funds for health care to the poor.

- The GOI should expand the public debate on health insurance, particularly to provide information on how insurance can be used by the public, and to discuss ways in which health insurance can help meet the needs of the poor.
- Experiment in health financing. Government should also undertake studies to develop other options for health financing to cover the poor and non-formal sectors. These include:
 - A more detailed study on the options for risk equalization schemes and universal, mandatory insurance schemes, probably through a mix of public and private enterprises.
 - Experiments in community financing schemes for the non-formal sector.
 - Focus on improving the quality of public health service delivery. The initial response of private health insurance will be to provide services to the better off segments of society. The public sector delivery system is expected to then provide a greater proportion of services to the poor. Therefore, increased investment in making the public system more efficient should benefit the poor.

IMPROVED PRIVATE HEALTH INSURANCE & HEALTH SYSTEMS RECOMMENDATIONS

- Improvements in the IRDA: It is important to distinguish health insurance from other forms of insurance in the IRDA Bill, and be explicit about the public health aims for insurance in the Bill. For example, objectives for health insurance would be that it provides a mechanism to encourage people to take better care of themselves; to get better value for money from health services; and to protect themselves from the financial burden of illness.

In addition to the Insurance Regulatory Development Authority that oversees general and life insurance regulation, a specialized independent agency (or agencies) should be established to oversee regulation of health insurance. The experience from other countries is that such specialization is needed because the frequency and nature of contacts involved in health insurance is greater and more intense compared to other types of insurance, and because of the particular needs for consumers, providers,

and insurers to understand quality of care issues in the management of the health insurance market. In addressing health insurance regulation, this agency would be expected to implement the following immediate strategies:

- Establish standard benefits packages upon which health insurance companies would compete. This would ensure comparability of packages and fairness in provision of benefits. It would also safeguard social objectives to include fairness in financing and provision of key services such as maternity care, preventive services, and care for catastrophic illnesses.
- Make treatment protocols and quality standards publicly available. Publish quality ratings of providers and institutions engaged in health insurance.
- Guarantee renewal of insurance policies, even as subscribers become ill.
- Reduce the ability to deny coverage to those with pre-existing conditions, and standardize and reduce insurers' ability to individually rate premiums.
- Establish an efficient conflict resolution mechanism, where conflicts can be arbitrated quickly and cheaply, outside the court system.
- Ensure that small scale community financing is allowable under the IRDA.
- Regularly disseminate information on the performance of insurance companies, with respect to such characteristics as: administrative costs, premiums charged for standard packages, frequency of complaints, differential charges by age and sex, clinical outcomes, and the inclusion of preventive care.
- Develop Quality Assurance Procedures. The introduction of private health insurance demands greater emphasis on quality assurance and standardization of health care. This is an opportunity that GOI should seize. In particular, accreditation schemes for hospitals and providers should be established. Specific treatment protocols need to be established and published, and utilization review mechanisms initiated. This may be one benefit that international private insurers can bring to the Indian market, but also must be pursued vigorously by the government. The government can support this through the development of a National Health Standards Council, which would develop or collate standards, and be a resource center for information on standards, disease factors, and related treatment costs.

GLOSSARY OF HEALTH INSURANCE AND RELATED TERMS

accountability: responsible, liable, explainable. To account means to furnish a justification or detailed explanation of financial activities or responsibilities; to furnish substantial reasons or convincing explanations. Accountability entails an obligation to periodically disclose in adequate detail and consistent form to all directly and indirectly responsible or properly interested parties. The concept is important in health *planning* and *regulation* programs (such as *health systems agencies*) which should be accountable to the public and those they affect for their actions. There is no specific or detailed agreement on what accountability is or how to assure it. In the United States, Public Law 93-641, for example, contains a variety of provisions designed to make the planning conducted under it accountable: agency governing boards must have a *consumer* majority; the affected parties must be represented on agency governing boards; data files, and meetings must all be open to the public; and decisions must be made according to established public procedures and criteria.

accreditation: the process by which an agency or organization evaluates and recognizes a program of study or an institution as meeting certain predetermined *standards*. The recognition is called accreditation. Similar assessment of individuals is called *certification*. Standards are usually defined in terms of: physical plant, governing body, administration, medical and other staff, and scope and organization of services. Accreditation is usually given by a private organization created for the purpose of assuring the public of the quality of the accredited (such as the *Joint Commission on Accreditation of Hospitals*). Accreditation standards and individual performance with respect to such standards are not always available to the public. In some situations public governments recognize accreditation in lieu of, accept as a basis of, or require it as a condition of *licensure*. Public or private payment programs often require accreditation as a condition of payment for covered services. Accreditation may either be permanent once obtained or for a specified period of time. Unlike a license, accreditation is not a condition of lawful practice, but is intended as an indication of high quality practice, although where payment is effectively conditioned on accreditation it may have the same effect.

actuary: in *insurance*, a person trained in statistics, accounting, and mathematics who determines policy *rates*, *reserves*, and *dividends* by deciding what assumptions should be made with respect to each of the risk factors involved (such as the frequency of occurrence of the *peril*, the average benefit that will be payable, the rate of investment earnings, if any, *expenses*, and *persistence* rates), and who endeavors to secure as valid statistics as possible on which to base his assumptions.

acquisition cost: the immediate cost of selling,

underwriting, and issuing a new *insurance policy*, including clerical costs, agents' commissions, advertising, and medical inspection fees. Also refers to the cost paid by a pharmacist or other retailer to a manufacturer or wholesaler for a supply of *drugs*.

adverse selection: disproportionate *insurance* of *risks* who are poorer or more prone to suffer *loss* or make claims than the average risk. It may result from the tendency for poorer risks or less desirable *insureds* (sick people) to seek or continue insurance to a greater extent than do better risks (healthy people), or from the tendency for the insured to take advantage of favorable options in insurance contracts. Favorable, as compared to adverse, selection, when intentional, is called *skimming*.

allowable charge: generic term referring to the maximum fee that a *third party* will use in reimbursing a *provider* for a given service. An allowable charge may not be the same as either a *reasonable*, *customary* or *prevailing charge* as the terms are used under the *Medicare* program in the United States.

anti-substitution laws: Laws that require the pharmacist to "dispense as written." The effect is to prohibit a pharmacist from substituting a different *brand name drug* for the one prescribed, or from substituting a *generic equivalent drug* in place of a *drug* prescribed by brand name, even if the drug that would be substituted is considered to be *therapeutically equivalent* to the drug prescribed and perhaps is less expensive. Drug reimbursement programs such as the *Maximum Allowable Cost Program*, which will limit reimbursement to the lowest cost at which a drug is generally available, will be more effective if they override anti-substitution laws.

assessment: in *insurance*, a charge upon *carriers* to raise funds for a specific purpose (such as meeting the administrative costs of a government required program) made by government (usually State government) or a special organization authorized by government, and provided for in law or regulation. Applied to all carriers handling a specific line of coverage subject to regulation by the government in question and based upon a formula.

assigned risk: a *risk* which *underwritten* do not care to insure (such as a person with hypertension seeking health insurance) but which, because of State law or otherwise, must be insured. Insuring assigned risks is usually handled through a group of insurers (such as all companies licensed to issue health insurance in the State) and individual assigned risks are assigned to the companies in turn or in proportion to their share of the State's total health insurance business. Assignment of risks is common in casualty insurance and less common in health insurance. As an approach to providing insurance to such risks, it can be contrasted with pooling of such risks (see *insurance*

pool) in which the *losses* rather than the risks are distributed among the group of insurers.

assignment: an agreement in which a *potential* assigns to another party, usually a *provider*, the right to receive payment from a *third-party* for the service the patient has received. Assignment is used instead of a patient paying directly for the service and then receiving reimbursement from public or private insurance programs.

beneficiary: a person who is eligible to receive, or is receiving, *benefits* from an *insurance policy* (usually) or *health maintenance organization* (occasionally, see *member*). Usually includes both people who have themselves contracted for benefits and their eligible *dependents*. See also *subscriber* and *insured*.

benefit: in *insurance*, a sum of money provided in an *insurance policy* payable for certain types of *loss*, or for covered services, under the terms of the policy. The benefits may be paid to the *insured* or on his behalf to others. In *prepayment* programs, like *HMOs*, benefits are the services the program will provide a *member* whenever, and to the extent *needed*.

benefits in kind: Health services provided to insured persons which are delivered, paid or reimbursed in full or in part by the scheme.

blanket medical expense: a provision (usually included as an added feature of a policy primarily providing some other type of coverage, such as loss of income insurance) which entitles the *insured* to collect, up to a maximum established in the policy, for all hospital and medical expenses incurred, without limitations on individual types of medical expenses.

capitation: a method of payment for health services in which an individual or institutional provider is paid a fixed, per capita amount for each person served without regard to the actual number or nature of services provided to each person. Capitation is characteristic of *health maintenance organizations* but unusual for physicians (see *fee-for-service*). Also, a method of support of health professional schools, in which each eligible school receives a fixed capitation payment for each student enrolled, called a capitation grant.

Capital Expenditure Review (CER): review of proposed *capital* expenditures of hospitals and/or other health facilities to determine the *need* for, and *appropriateness* of, the proposed expenditures. The review is done by a designated *regulatory* agency such as a *State health planning and development agency* and has a sanction attached which prevents (see *certificate-of-need*) or discourages unneeded expenditures.

case-mix: the diagnosis-specific makeup of a health program's work-load. Case-mix directly influences the *length of stays* in, and *intensity*, *cost* and *scope* of the services provided by a hospital or other health program.

cash benefits: cash payments made by the scheme to compensate for loss of income in case of illness, accident

or maternity, or for additional expenditures in case of maternity or death.

catastrophic health insurance: health insurance which provides protection against the high cost of treating severe or lengthy *illnesses* or *disabilities*. Generally such policies cover all or a specified percentage of medical expenses above an amount that is the responsibility of the insured himself (or the responsibility of another insurance policy up to the maximum limit of liability). Under pending *NHI* proposals of this type, protection would typically begin after an individual or family unit had incurred medical expenses equal to a specified dollar amount (e.g. \$2,000 within a 12-month period) or a specified percentage of *income* (e.g. fifteen percent); or had been in a medical institution for a specified period (e.g. 60 days). Individuals would be liable for all costs up to the specified limits. However, in the absence of any effective prohibition against doing so, they could be expected to obtain health insurance protection for costs below the catastrophic limits. Generally there is no maximum amount of coverage under these plans; however, many include some *coinsurance*. (see also *major medical*).

catchment area: a geographic area defined and served by a health program or institution such as a hospital or *community mental health center*. Delineated on the basis of such factors as population distribution, natural geographic boundaries, and transportation accessibility. Should be contrasted with service, medical market, or *medical trade area*. All residents of the area needing the services of the program are usually eligible for them, although eligibility may also depend on additional criteria (age or *income*). Residents of the area may or may not be limited to obtaining services from the program, be known to, or *enrolled* in the program. The program may or may not be limited to providing services to residents of the area or under any obligation to know of, *register*, or have the capacity to serve all residents of the area.

certification: the process by which a governmental or nongovernmental agency or association evaluates and recognizes an individual, institution or educational program as meeting predetermined *standards*. One so recognized is said to be certified. Essentially synonymous with *accreditation*, except that certification is usually applied to individuals an accreditation to institutions. Certification programs are generally nongovernmental and do not exclude the uncertified from *practice* as do *licensure* programs. In the *PSRO* and other *regulatory* programs, certification of services means that their provision has been approved and payment for them assured (see *certificate-of-need*).

circumvention fee: fixed fee which is due if an *insured* person contacts directly a provider on a higher level of care than on the designated entry level of the health care delivery system. For example, when a person contacts a specialist without seeing a general practitioner first and being referred to the specialist.

claim: a request to an *insurer* by an *insured* person (or, on his behalf, by the provider of a service or good) for payment of benefits under an *insurance policy*.

claims review: review of *claims* by governments, *medical foundations*, *PSROs*, *insurers* or others responsible for payment to determine liability and amount of payment. This review may include determination of the eligibility of the claimant or *beneficiary*; of the eligibility of the *provider* of the *benefit*; that the benefit for which payment is claimed is covered; that the benefit is not payable under another policy; and that the benefit was *necessary* and of *reasonable cost* and *quality*.

coinsurance: a *cost-sharing* requirement under a health insurance policy which provides that the *insured* will assume a portion or percentage of costs of covered services. The health insurance policy provides that the *insurer* will reimburse a specified percentage (usually 80 percent) of all, or certain specified covered medical expenses in excess of any *deductible* amounts payable by the insured. The insured is then liable for the remaining percentage of the costs, until the maximum amount payable under the insurance policy, if any, is reached.

community rating: a method of establishing *premiums* for health *insurance* in which the premium is based on the average cost of actual or anticipated health care used by all *subscribers* in a specific geographic area or industry and does not vary for different groups or subgroups of subscribers or with such variables as the group's *claims* experience, age, sex, or *health status*.

compulsory insurance: an insurance program in which legislation defines the population and benefits covered, the conditions of eligibility, and the sources of funds in a scheme. A plan may be compulsory only for an employer (coverage must be offered to employees and a specified portion of the *premium* paid, if they opt to take it) or for individuals as well. Any universal public plan is necessarily compulsory in the payment of taxes to support the plan is not optional with the individual.

concurrent review: review of the medical *necessity* of *hospital* or other health facility *admissions* upon or within a short period following an admission and the periodic review of services provided during the course of *treatment*. The initial review usually assigns an appropriate *length of stay* to the admission (using *diagnosis specific criteria*) which may also be reassessed periodically. Where concurrent review is required, payment for unneeded hospitalizations or service is usually denied.

contingency reserve: funds, deriving from contributions or other sources, which are set aside by the scheme to meet unforeseen income or expenditure deviations.

continued stay review: review during a *patient's* hospitalization to determine the medical *necessity* and *appropriateness* of continuation of the patient's stay at a hospital level of care. It may also include assessment of the *quality* of care being provided. Occasionally used for similar review of patients in other health facilities (see

medical review). Used in the *PSRO* and *Medicare* programs in the United States, where it is sometimes called extended duration review (see also *concurrent review*).

contribution ceiling: the maximum amount of earnings which is subject to social security contributions. Earnings up to this ceiling are therefore termed insurable earnings.

contributory insurance: *group insurance* in which all or part of the *premium* is paid by the employee, the remainder, if any, being paid by the employer or union. In this context, noncontributory insurance is insurance in which the employer pays all the premium. So called because the *risk*, or employee, contributes to the cost of the insurance as well as the *insured* (see also *enrollment period*).

copayment: a type of *cost sharing* whereby *insured* or covered persons pay a specified flat amount per unit of service or unit of time (e.g. \$2 per visit, \$10 per inpatient hospital day), their *insurer* paying the rest of the cost. The copayment is incurred at the time the service is used. The amount paid does not vary with the cost of service (unlike *coinsurance*, which is payment of some percentage of the cost).

cost center: accounting device whereby all related *costs* attributable to some "center" within an institution, such as an activity, department, or program (e.g. hospital burn center), are segregated for accounting or reimbursement purposes. Contrasts with segregating costs of different types, such as *nursing*, *drugs*, or *laundry*, regardless of which "center" incurred them.

cost of insurance: the amount which a policyholder pays to the *insurer* minus what he gets back from it. This should be distinguished from the *rate* for a given unit of insurance (\$10 for a \$1000 life insurance policy). Such costs, which may be difficult to obtain and are rarely compared, are roughly approximated by the *loading* or the ratio of amounts paid in benefits to income produced from premiums (see also *expenses*).

cost-related reimbursement: one method of payment of medical care programs by *third parties* (typically *Blue Cross* plans or government agencies in the United States), for services delivered to patients. In cost-related systems, the amount of the payment based on the *costs* to the provider of delivering service. The actual payment may be based on any one of several different formulae, such as full cost, full cost plus an additional percentage, *allowable costs*, or a fraction of the costs. Other reimbursement schemes are based on the *charges* for the services delivered, or on budgeted or anticipated costs for a future time period (*prospective reimbursement*).

cost sharing: provisions of a health *insurance policy* which require the *insured* or otherwise covered individual to pay some portion of his covered medical expenses. Several forms of cost-sharing are employed, particularly *deductibles*, *coinsurance* and *copayments*. A deductible is a set amount which a person must pay before any payment of *benefits* occurs. A copayment is usually a fixed amount to

be paid with each service. Coinsurance is payment of a set portion of the cost of each service. Cost-sharing does not refer to or include the amounts paid in *premiums* for the *coverage*.

coverage: the guarantee against specific *losses* provided under the terms of an *insurance policy*. Frequently used interchangeably with *benefits* or protection. The extent of the insurance afforded by a policy. Often used to mean insurance or an insurance contract.

creaming: see *skimming*.

credentialing: the recognition of *professional* or technical competence. The credentialing process may include *registration*, *certification*, *licensure*, professional association membership, or the award of a degree in a field. Certification and licensure affect the supply of *health manpower* by controlling entrance into *practice*, and influence the stability of the labor force by affecting geographic distribution, mobility, and retention of workers. Credentialing also determines the *quality* of personnel by providing *standards* for evaluating competence, and defining the scope of functions and how personnel may be used.

customary charge: generally, the amount which a physician normally or usually *charges* the majority of patients.

deductible: the amount of loss or expense that must be incurred by an *insured* or otherwise covered individual before an *insurer* will assume any liability for all or part of the remaining cost of covered services. Deductibles may be either fixed dollar amounts or the value of specified services (such as two days of hospital care or one physician visit). Deductibles are usually tied to some reference period over which they must be incurred (e.g. \$100 per calendar year, *benefit period*, or *spell of illness*). Deductibles in existing policies are generally of two types: (1) static deductibles which are fixed dollar amounts, and (2) dynamic deductibles which are adjusted from time to time to reflect increasing medical prices. A third type of deductible is proposed in some *national health insurance* plans: a *sliding scale deductible*, in which the deductible is related to *income* and increases as income increases.

demand or demand schedule: in health economics, the varying amount of a good or service sought at varying prices, given constant income and other factors. Demand must be distinguished from *utilization* (the amount of services actually used), and *need* (for various reasons services are often sought which either the *consumer* or *provider* feel are unneeded). It is not always translated into use, particularly when queues develop (see also *supply*, and *elasticity of demand*).

disability income insurance: a form of health insurance that provides periodic payments to replace *income* when the *insured* is unable to work as a result of *injury* or *disease* (see also *workmen's compensation*).

dispensing fee: a fee charges by a pharmacist for filling

a *prescription*. One of two ways that *pharmacists* charge for the service of filling a prescription, the other being a standard percentage markup on the *acquisition cost* of the *drug* involved. A dispensing fee is the same for all prescriptions, thus representing a larger mark-up cost of an inexpensive drug or a small prescription than on an expensive drug or large prescription. However, it reflects the fact that a pharmacist's service is the same whatever the cost of the drug. Some pharmacists combine the two approaches, using a percentage mark-up with a minimum fee.

economies of scale: cost savings resulting from aggregation of resources and/or mass production. In particular, it refers to decreases in average cost when all factors of production are expanded proportionately. For example, hospital costs for a unit of service are generally less in 300 than 30 bed hospitals. (There is some evidence that they may be greater in 1,000 bed than 300 bed hospitals, a diseconomy of scale). Frequently used, less accurately, to refer to savings achieved when underused resources are used more efficiently. For example, when many individuals use the same product, or when, health care facilities share in the costs and use of expensive equipment (e.g. automated laboratory equipment) or otherwise underused and highly trained personnel (e.g. open-heart surgery teams).

effectiveness: the degree to which diagnostic, preventive, therapeutic or other action or actions achieves the intended result. Effectiveness requires a consideration of *outcomes* to measure. It does not require consideration of the cost of action, although one way of comparing the effectiveness of actions with the same or similar intended results is to compare the ratios of their effectiveness to their costs. The Federal Food, Drug, and Cosmetic Act requires prior demonstration of effectiveness for most *drugs* marketed for human use. No similar requirement exists for most other medical action paid for or *regulated* under Federal or State law in the United States. Usually synonymous with *efficacy* in common use. (see also *quality*, *efficiency*).

efficacy: commonly used synonymously with *effectiveness*, but may usefully be distinguished from it by using efficacy for the results of actions undertaken under ideal circumstances and effectiveness for their results under usual or normal circumstances. Actions can thus be efficacious and effective, or efficacious and ineffective, but not the reverse.

efficiency: the relationship between the quantity of inputs or resources used in the production of medical services and the quantity of outputs produced. Efficiency has three components: input productivity (technical efficiency), input mix (economic efficiency), and the scale of operation. Efficiency is usually measured by indicators such as output per man hour or cost per unit of output. However, such indicators fail to account for the numerous relevant dimensions (such as *quality*) of both inputs and

outputs and are, therefore, only partial measures. Colloquially, efficiency should probably be measured in terms of the cost of achieving various health outcomes defining it in terms of productivity assumes that what is produced is *efficacious* and used in an effective manner.

elasticity of demand: in health economics, a measure of the sensitivity of demand for a product or *service* to changes in its price (price elasticity) or the income of the people demanding the product or service (income elasticity). Price elasticity is the ratio of the resulting percentage change in demand to a given percentage change in price. Price elasticity of demand for health services allows one to predict the effect on demand of different *cost sharing* provisions in proposed *NHI* programs and thus aids in predicting the differing stress their enactment would place on the health system.

eligibility conditions: conditions that *insured* persons must meet in order to be entitled to the benefits of the scheme. These may include a: maximum duration of benefits (the time during which the insured may receive benefits); qualifying period (minimum period of contributions before the insured person or dependants can qualify for benefits); waiting period (the time an insured person has to wait before qualifying for specific benefits).

enroll: to agree to participate in a contract for *benefits* from an *insurance* company or *health maintenance organization*. A person who enrolls is an enrollee or *subscriber* (see also *member* and *beneficiary*). The number of people (and their *dependents*) enrolled with an insurance company or *HMO* is its enrollment (see also *open enrollment*).

excise tax: a single-stage commodity tax (i.e. a tax levied on a commodity only once as it passes through the production process to the final consumer). An excise tax is narrowly based; enabling legislation to specify precisely which products are taxed, as well as the tax rate. Sales taxes are more broadly based; their tax base comprises many commodities and legislation designates those commodities not subject to tax. Excise taxes are commonly assessed on automobiles, cigarettes, liquor or gasoline. They are sometimes levied in hopes of discouraging the use of the product. For example, an excise tax on cigarettes might discourage smoking by raising its cost and revenues from it might be used to fund cancer screening programs.

enrollment period: period during which individuals may *enroll* for *insurance* or *health maintenance organization* benefits. There are two kinds of enrollment periods, for example, for *supplementary medical insurance* of *Medicare* in the United States: the initial enrollment period (the seven months beginning three months before and ending three months after the month a person first becomes eligible, usually by turning 65); and the general enrollment period (the first three months of each year). Most *contributory group insurance* has an annual enrollment period when members of the group may elect to begin contributing and become covered (see also *open enrollment*).

exclusions: specific *hazards*, *perils* or conditions listed in an *insurance* or medical care coverage policy for which the policy will not provide benefit payments. Common exclusions may include *preexisting conditions*, such as heart disease, diabetes, hypertension or a pregnancy which began before the policy was in effect. Because of such exclusions, persons who have a serious condition or disease are often unable to secure insurance coverage, either for the particular disease or in general. Sometimes excluded conditions are excluded only for a defined period after coverage begins, such as nine months for pregnancy or one year full exclusions. Exclusions are often permanent in *individual health insurance*, temporary (e.g. one year) for small groups in *group insurance*, and uncommon for large groups capable of absorbing the extra risk involved.

expenses: in *insurance*, the cost to the *insurer* of conducting its business other than paying *losses*, including *acquisition* and administrative costs. Expenses are included in the *loading*.

experience rating: a method of establishing *premiums* for health insurance in which the premium is based on the average cost of actual or anticipated health care used by various groups and subgroups of *subscribers* and thus varies with the health experience of groups and subgroups or with such variables as age, sex, or health status. It is the most common method of establishing premiums for health insurance in private programs (see also *community rating*).

externality: in health economics, something that results from an *encounter* between a *consumer* and *provider*, which confers benefits or imposes *costs* on others, and is not considered in making the transaction (its value, the external cost, not being reflected in any *charge* for the transaction). Pollution is the classic example. In health, an externality of immunizations is the protection that they give the unimmunized, since that protection is not considered when an individual immunization is obtained or priced.

factoring: the practice of one individual or organization selling its accounts receivable (unpaid bills) to a second at a discount. The latter organization, called the 'factor,' usually, but not always, assumes full risk of loss if the accounts prove uncollectible. In health services delivery, the expression generally refers to a hospital's or physician's sale of unpaid bills to a collection agent.

fee for service: method of *charging* whereby a physician or other practitioner bills for each *encounter* or service rendered. This is the usual method of billing by the majority of the country's physicians. Under a fee for service payment system, expenditures increase not only if the fees themselves increase but also if more units of service are charged for, or more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita or *prepayment* systems, where the payment is not changed with the number of services actually used or if none are used. While the fee-for-service system is now generally limited to physicians, dentists, podiatrists and

optometrists, a number of other practitioners, such as *physician assistants*, have sought reimbursement on a fee for service basis. (see also *fee schedule*, *fractionation* and *capitation*).

fee schedule: a listing of accepted *charges* or established allowances for specified medical or dental procedures. It usually represents either a physician's or *third party's* standard or maximum charges for the listed procedures (see *relative value scale*).

fiduciary: relating to or founded upon a trust or confidence. A fiduciary relation exists where an individual or organization has an explicit or implicit obligation to act in behalf of another person's or organization's interests in matters which affect the other person or organization. A *physician* has such a relation with his *patient* and a hospital trustee with a hospital. Because a fiduciary relationship with a *provider* obligates one to act in the interests of the provider, people with such relationships are defined as providers in the United States, rather than as *consumers*, for such purposes as determining whether a *health systems agency* governing board has a consumer majority.

fractionation: the practice of *charging* separately for several services or components of a service which were previously subject to a single charge or not charged for at all. The usual effect is that the total charge is increased. The practice is most commonly sent as a response to limiting increases in the charge which is fractionated.

fraud: intentional misrepresentation by either *providers* or *consumers* to obtain services, obtain payment for services, or claim program eligibility. Fraud may include the receipt of services which are obtained through deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or claiming payment for services which were never delivered or received. Fraud is illegal and carries a penalty when proven.

free choice of provider: choice of health care provider by insured person without restriction.

free rider problem: if persons can benefit from a scheme without contributing to the scheme.

grace period: a specified period, after a *premium* payment is due on an insurance policy, in which the policyholder may make such payment, and during which the protection of the policy continues.

group insurance: any *insurance* plan by which a number of employees of an employer (and their *dependents*), or members of a similar homogeneous *group*, are *insured* under a single policy, issued to their employer or the *group*, are *insured* under a single policy, issued to their employer or the *group* with individual *certificates of insurance* given to each insured individual or *family*. Individual employees may be insured automatically by virtue of employment, only on meeting certain conditions (employment for over a month), or only when they elect to be insured (and usually

to make a contribution to the cost of the insurance). Group health insurance is usually *experience rated* (except for small groups, all of which are insured by an individual company in the same area are given the same rate by that company) and less expensive for the insured than comparable individual insurance (partly because an employed population is generally healthier than the general population, and partly because of lower administrative costs, especially in marketing and billing). Note that the policy holder or *insured* is the employer not the employees (see also *contributory insurance*).

hazard: a situation or event which introduces, or increases the probability of, occurrence of a *loss* arising from a *peril*, or that increases the extent of a loss; such as slippery floors, unsanitary conditions, or congested traffic.

health insurance: *insurance* against loss by *disease* or accidental bodily *injury*. Such insurance usually covers some of the medical costs of treating the disease or injury, may cover other losses (such as loss of present or future earnings) associated with them and may be either *individual* or *group* insurance.

Health Maintenance Organization (HMO): an entity with four essential attributes: (1) an organized system for providing health care in a geographic area, which entity accepts the responsibility to provide or otherwise assure the delivery of (2) an agreed upon set of *basic* and *supplemental health* maintenance and treatment *services* to (3) a voluntarily enrolled group of persons, and (4) for which services the HMO is reimbursed through a predetermined, fixed, periodic *prepayment* made by or on behalf of each person or family unit *enrolled* in the HMO without regard to the amounts of actual services provided. The HMO is responsible for providing most health and medical care services required by enrolled individuals of *families*. These services are specified in the contract between the HMO and the enrollees. The HMO must employ or contract with health care providers who undertake a continuing responsibility to provide services to its enrollees. The prototype HMO is the Kaiser-Permanente system, a *prepaid group practice* located on the West Coast. However, *medical foundations* sponsored by groups of physicians are included under the definition. HMOs are of public policy interest because the prototypes appear to have demonstrated the potential for providing high *quality* medical services for less money than the rest of the medical system. Specifically, rates of hospitalization and surgery are considerably less in HMOs than occurs in the system outside such prepaid groups, although some feel that earlier, *skimping* or *skimming* may be better explanations (see also *prepaid health plans (PHPs)*, *individual practice associations*).

incur: in *insurance*, to become *liable* for a *loss*, claim or expense. Cases or losses incurred are those occurring within a fixed period for which an insurance plan becomes liable whether or not reported, adjusted and paid.

indemnity, indemnity benefits: under health *insurance*

policies, *benefits* in the form of cash payments rather than services. The indemnity insurance contract usually defines the maximum amounts which will be paid for the covered services. In most cases, after the provider of service has billed the patient in the usual way, the insured person submits to the insurance company proof that he has paid the bills and is then reimbursed by the company in the amount of the covered costs, making up the difference himself. In some instances, the provider of service may complete the necessary forms and submit them to the insurance company directly for reimbursement, billing the patient for costs which are not covered. Indemnity benefits are contrasted with *service benefits*.

Independent Professional Review (IPR): another name for *medical review* required by Medicaid for inpatients in long-term care facilities.

indexed: describes an amount which is regularly adjusted in proportion to changes in some index, (e.g. social security payments are now indexed to (or adjusted to reflect changes in) the *Consumer Price Index*. Some proposed NHI plans index *premiums*, *cost-sharing*, catastrophic thresholds, income levels, or reimbursement rates to the CPI.

individual health insurance: health *insurance* covering an individual (and usually his *dependents*) rather than a group. Individual insurance usually offers *indemnity benefits* than *group insurance*.

Individual Practice Association (IPA): a partnership, corporation, association, or other legal entity which has entered into an arrangement for provision of their services with persons who are *licensed to practice medicine, osteopathy, dentistry*, or with other *health manpower* (a majority of whom are licensed to practice medicine or osteopathy), which arrangement provides: that such persons provide their professional services in accordance with a compensation arrangement established by the entity; and to the extent feasible (i) that such persons use such additional professional personnel, allied health professions personnel, and other health personnel as are available and appropriate for the *effective and efficient* delivery of the services, (ii) for the sharing by such persons of *medical* and other records, equipment, and professional, technical and administrative staff, and (iii) for the arrangement and encouragement of the *continuing education* of such persons in the field of clinical medicine and related areas. IPAs are one source of professional services for HMOs and are modeled after *medical foundations*.

insurable risk: a *risk* which has the following attributes: it is one of a large homogeneous group of similar risks; the *loss* produced by the risk is definable and quantifiable; the occurrence of loss in individual cases is accidental or fortuitous; the potential loss is large enough to cause hardship; the cost of insuring is economically feasible; the chance of loss is calculable; and it is sufficiently unlikely that loss will occur in many individual cases at the same time.

insurance: the contractual relationship which exists when one party, for a consideration, agrees to reimburse another for loss to a person or thing caused by designated contingencies. The first party is the *insurer*; the second, the *insured*; the contract, the *insurance policy*; the consideration, the *premium*; the person or thing, the *risk*; and the contingency, the *hazard* or *peril*. Generally, a formal social device for reducing the risk of losses for individuals by spreading the risk over groups. Insurance characteristically, but not necessarily, involves equitable contributions by the insured, pooling of risks, and the transfer of risks by contract. Insurance may be offered on either a *profit* or nonprofit basis, to *groups* or individuals (see also *prepayment*).

insurance pool: an organization of *insurers* or *reinsurers* through which particular types of *risks* are shared or pooled. The *risk* of high *loss* by any particular insurance company is transferred to the group as a whole (the insurance pool) with *premiums*, *losses*, and *expenses* shared in agreed amounts. The advantage of a pool is that the size of expected losses can be predicted for the pool with much more certainty than for any individual party to it. Pooling arrangements are often used for *catastrophic coverage* or for certain high risk populations like the *disabled*. Pooling may also be done within a single company by pooling risks insured under various different policies so that high losses incurred by one policy are shared with others (see also *assigned risk*).

insured: the individual or organization protected in case of *loss* under the terms of an *insurance policy*. The insured is not necessarily the *risk*, the person whose risk of loss from *accident* or *sickness* is protected against. In *group insurance* the employer is the insured, the employees are the *risks*.

insurer: the party to an *insurance policy* who contracts to pay *losses* or render services.

intermediary: a public or private agency or organization selected by *providers* of health care which enters into an agreement with the financier (usually a government agency), to pay *claims* and perform other functions for financier with respect to such providers. Usually, but not necessarily, a *Blue Cross plan* or private insurance company. (see also *carrier* and *fiscal agent*).

joint purchasing agreement: a formal agreement among two or more *health facilities* or programs to purchase professional services, equipment or supplies. The agreements simplify purchasing or result in *economies of scale* intended to lower costs to the programs. The purchased services or supplies may be shared or simply distributed among the programs.

length of stay (LOS): the length of an *inpatient's* stay in a hospital or other *health facility*. It is one measure of use of health facilities, reported as an average number of days spent in a facility per *admission* or discharge. It is calculated as follows: total number of days in the facility for all discharges and *deaths* occurring during a period

divided by the number of discharges and deaths during the same period. In *concurrent review* an appropriate length of stay may be assigned each patient upon admission. Average lengths of stay vary and are measured for people with various ages, specific diagnoses, or sources of payment.

liability: something one is bound to do, or an obligation one is bound to fulfill, by law and justice. A liability may be enforced in court. Liabilities are usually financial or can be expressed in financial terms. Also, the probable cost of meeting such an obligation.

license: a permission granted to an individual or organization by competent authority, usually public, to engaging in a *practice*, occupation or activity otherwise unlawful. Licensure is the process by which the license is granted. Since a license is needed to begin lawful practice, it is usually granted on the basis of examination and/or proof of education rather than measures of performance. License when given is usually permanent but may be conditioned on annual payment of a fee, proof of *continuing education*, or proof of competence. Common grounds for revocation of a license include incompetence, commission of a crime (whether or not related to the licensed practice) or moral turpitude. Possession of a medical license from one State may (*reciprocity*) or may not suffice to obtain a license from another. There is no national licensure system for health *professionals*, although requirements are often so nearly standardized as to constitute a national system (see *accreditation*, *certification*, and *institutional licensure*).

limits on liability: in *insurance*, limits on dollar coverage contained in an insurance policy. *Malpractice insurance* generally contains such limits on the amounts payable for an individual claim, or in the policy year (e.g. \$100,000 to \$200,000, and \$300,000 to \$600,000, respectively). Excess coverage describes insurance with limits higher than these conventional amounts. It may also be used to refer to limits on *professional liability* imposed by law. Several states in the United States have enacted legislation, for example, which would place a limit of \$500,000 on any malpractice award. Such laws are being challenged as to their legality and, in some instances, have been ruled unconstitutional.

loading: in *insurance*, the amount added to the actuarial value of the *coverage* (expected or average amounts payable to the *insured*) to cover the expense to the *insurer* of securing and maintaining the business (i.e. the amount added to the pure premium needed to meet anticipated *liabilities* for *expenses*, *contingencies*, *profits* or special situations. Loading costs for *group health insurance* range from 5 to 25 percent of premiums; for individual health insurance they go as high as 40 to 60 percent.

locality: in *Medicare*; the geographic area from which a *carrier* derives *prevailing charges* for the purpose of making *reasonable charge* determinations. Usually, a locality is a political or economic subdivision of a State and should include a cross-section of the population with respect to

economic and other characteristics (see *catchment*).

long-term care: health and/or personal care services required by persons who are chronically ill, aged, disabled, or retarded, in an institution or at home, on a long-term basis. The term is often used more narrowly to refer only to long-term institutional care such as that provided in *nursing homes*, homes for the retarded and mental hospitals. *Ambulatory services*, like *home health care*, which also can be provided on a long-term basis, are seen as *alternatives to long-term institutional care*.

major medical: *insurance* designed to offset heavy medical expenses resulting from catastrophic or prolonged *illness* or *injuries*. Generally, such policies do not provide *first dollar coverage*, but do provide benefit payment of 75 to 80 percent of all types of medical expenses above certain base amount paid by the *insured*. Most major medical policies sold as private insurance contain maximums on the total amount that will be paid (such as \$50,000); thus, they do not provide *last dollar coverage* or complete protection against catastrophic costs. However, there is a trend toward \$250,000 limits or even unlimited plans. In addition, benefit payments are often 100 percent of expenses after the individual has incurred some large amount (\$500 to \$2,000) of *out-of-pocket expenses*.

major surgery: surgery in which the operative procedure is hazardous. Major surgery is irregularly distinguished from *minor surgery* according to whether or not it requires a general anesthetic, involves an amputation above the ankle or wrist, or includes entering one of the body cavities (abdomen, chest or head).

malpractice: *professional* misconduct or lack of ordinary skill in the performance of a professional act. A practitioner is *liable* for damages or injuries caused by malpractice. Such liability, for some professions like medicine, can be covered by *malpractice insurance* against the costs of defending suits instituted against the professional and/or any damages assessed by the court, usually up to a maximum limit. Malpractice requires that the patient demonstrate some *injury* and that the injury be negligently caused (see *limits on liability*).

malpractice insurance: *insurance* against the *risk* of suffering financial damage because of *malpractice*.

marginal cost: in health economics, the change in the total *cost* of producing services which results from a small or unit change in the quantity of services being produced. Marginal cost is the appropriate cost concept to consider when contemplating program expansion or contraction. *Economies of scale* will result from the expansion of a program when marginal cost is less than average or unit cost.

medical audit: detailed retrospective review and evaluation of selected *medical records* by qualified *professional* staff. Medical audits are used in some *hospitals*, *group practices*, and occasionally in private independent practices for evaluating professional performance by comparing it with accepted *criteria*,

standards and current professional judgment. A medical audit is usually concerned with the care of a given illness and is undertaken to identify deficiencies in that care in anticipation of educational programs to improve it (see concurrent review).

medical foundation: an organization of *physicians*, generally sponsored by a State or local medical association. Sometimes called a foundation for medical care. It is a separate and autonomous corporation with its own board of directors. Every physician member of the medical society may apply for membership in the foundation and, upon acceptance, participate in all its activities. A foundation is concerned with the delivery of medical services at reasonable cost. It believes in the free choice of a physician and hospital by the patient, *fee-for-service* reimbursement and local *peer review*. Many foundations operate as *prepaid group practices* or as an *individual practice association* for an *HMO*. While these are prepaid on a *capitation* basis for services to some or all of their patients, they still pay their individual members on a fee-for-service basis for the services they give. Some foundations are organized only for peer review purposes or other specific functions.

medical indigency: the condition of having insufficient *income* to pay for adequate medical care without depriving oneself or *dependents* of food, clothing, shelter, and other essentials of living. Medical indigency may occur when a self-supporting individual, able under ordinary conditions to provide basic maintenance for themselves and their *family*, is, in time of catastrophic illness, unable to finance the total cost of medical care.

medically underserved area: a geographic location (i.e. an urban or rural area) which has insufficient *health resources* (manpower and/or facilities) to meet the medical *needs* of the resident population. *Physician shortage area* applies to a medically underserved area which is particularly short of physicians. Such areas are also sometimes defined by measuring the *health status* of the resident population rather than the supply of resources, an area with an unhealthy population being considered underserved.

medically underserved population: the population of an urban or rural area with a shortage of personal *health resources* (manpower and/or facilities) to meet the medical *needs* of the resident population. *Physician shortage area* applies to a medically underserved population that may not reside in a particular *medically underserved area*, or be defined by its place of residence. Thus migrants, Native Americans or the inmates of a prison or mental hospital may constitute such a population.

medical review: review by a team composed of physicians and other appropriate health and social service personnel of the condition and need for care, including a medical evaluation, of each *inpatient* in a *long-term care facility*. By law, the team must review the: care being provided in the facilities; adequacy of the services available in the facilities to meet the current health *needs* and

promote the maximum physical well-being of the patients; *necessity* and desirability of the continued placement of such patients in the facilities; and *feasibility of meeting* their health care needs through alternative institutional or noninstitutional services. Medical review differs from *utilization review* in that it requires evaluation of each individual patient and an analysis of the *appropriateness* of his specific treatment in a given institution, whereas utilization review is often done on a sample basis, with special attention to certain procedures, conditions or *length of stay* (see also *continued stay review*).

member: a person who is eligible to receive, or is receiving, benefits from a *health maintenance organization* (usually) or *insurance policy* (occasionally; see *beneficiary*). Usually includes both people who have themselves *enrolled* or subscribed for benefits and their eligible *dependents* (see also *subscriber* and *insured*).

moral hazard: ability of an insured person to exploit benefits unduly to the detriment or disadvantage of others, or the scheme as a whole, without having to bear the full financial consequences of his behavior

mutual benefit associations: fraternal or social organizations or corporations for the relief of members of the organization from specified *perils* or costs such as the costs of *illness*. Such associations pay *losses* with assessments on their members intended to liquidate specific losses rather than by fixed *premiums* payable in advance.

mutual insurance company: insurance companies with no capital stock, owned by the policyholders. Trustees of the company are chosen by the policyholders. Earnings over and above payment of *losses*, operating *expenses*, and *reserves* are the property of the policyholders and returned to them in some way such as dividends or reduced *premiums* (see also *stock insurance company*).

National Health Insurance (NHI): Programs in which the government insures or otherwise arranges financing for health care without arranging for, owning or operating it (though they may include some measure of *regulation* of the financed services). A term not yet defined in the United States (see *national health service*).

national health service: often used synonymously with *national health insurance* (incorrectly). They are sometimes usefully distinguished by applying the former to health programs in which the national government directly operates a health system which serves some of all of its citizens and the latter to those in which it finances without owning or operating the services.

need: some thing or action which is essential, indispensable, required or cannot be done or lived without; a condition marked by the lack or want of some such thing or action. The presence or absence of a need can and should be measured by an objective *criterion* or *standard*. Needs may or may not be perceived or expressed by the person in need and must be distinguished from *demands*,

expressed desires whether or not needed. Like *appropriateness*, need is frequently and irregularly used in health care with respect to *health facilities* and services (see *certificate-of-need*), and people (see *medically needy*). It is thus important to specify what thing or action's need is being considered, by what criteria the need is to be established, by whom (*provider, consumer, or third party*), and with what effect (since payment for services by *insurance* is, for instance, sometimes conditioned upon the necessity of their provision).

occupancy rate: a measure of *inpatient health facility* use, determined by dividing *available bed days* by *patient days*. It measures the average percentage of a hospital's *beds* occupied and may be institution-wide, or specific for one *department* or *service*.

open enrollment: a period when new *subscribers* may elect to *enroll* in a health *insurance* plan or *prepaid group practice*. Open enrollment periods may be used in the sale of either *group* or *individual insurance* and be the only period of a year when insurance is available. Individuals perceived as high-risk (perhaps because of a *preexisting condition*) may be subjected to high *premiums* or *exclusions* during open enrollment periods. The term also refers to periodic opportunities for the general public, on a first come, first served basis, to join an *HMO*. The United States law presently requires that HMOs have at least one annual open enrollment period during which an HMO accepts, "up to its capacity, individuals in the order that they apply" unless the HMO can demonstrate to government that open enrollment would threaten its economic viability. In such cases, government can waive the open enrollment requirement for a period of up to three years.

opportunity cost: in health economics, the value that resources, used in a particular way, would have if used in the best possible or another specified alternative way. When opportunity costs exceed the value the resources have in the way they are being used, they represent lost opportunities to get value from the resources. One opportunity cost of devoting physician time to *tertiary care* is the lost value of devoting the same time to *primary care*. Opportunity costs are the appropriate *cost* concept to consider when making resource allocation decisions. *Actual costs* often, but not always, can be assumed to represent (be proportional to) opportunity costs (see also *marginal cost*).

optional services: services which may be provided or covered by a health program or *provider* and, if provided, will be paid for in addition to any *required services* which must be offered.

over-billing: additional charge made by the provider over and above the charge listed in the fee schedule. This additional amount is borne by the patient. In some national health insurance systems, over-billing is not allowed.

out-of-pocket payments or costs: those borne directly by a *patient* without benefit of *insurance*, sometimes called direct costs. Unless *insured*, these include patient

payments under *cost-sharing* provisions.

outpatient: a *patient* who is receiving *ambulatory care* at a hospital or other *health facility* without being *admitted* to the facility. Usually does not mean people receiving services from a *physician's* office or other program which does not also give *inpatient* care. Outpatient care refers to care given outpatients, often in organized programs.

participation (participating): a *physician* participates in an *insurance plan* when he agrees to accept the plan's pre-established fee or *reasonable charge* as the maximum amount which can be collected for services rendered. A non-participating physician may charge more than the insurance program's maximum allowable amount for a particular service. The patient is then liable for the excess above the allowed amount. This system was developed in the private sector as a method of providing the *insured* with specific health care services at no *out-of-pocket* costs. A hospital or other health program is called a participating *provider* when it meets the various requirements of, and accepts reimbursement from, a public or private health insurance program.

patient days: a measure of institutional use, usually measured as the number of *inpatients* at a specified time (e.g. midnight). See also *occupancy rate*.

patient mix: the number and types of *patients* served by a *hospital* or other health program. Patients may be classified according to their homes (see *patient origin study*).

pay-as-you-go system: a system of financing an insurance scheme under which the total expenditure for benefits and administration of a given period are met out of the income (from contributions and other sources) of the same period. Pay-as-you-go insurance schemes do not accumulate reserves except for contingency reserves.

payroll deduction: a specified amount taken out of pay to finance a *benefit*. Payroll deductions may be either a set *payroll tax*, at the social security tax, or a required payment for a benefit, for example, a *group health insurance premium*. A payroll deduction generally refers to any amount withheld from the earnings of an employee.

peer review: generally, the evaluation by *practicing physicians* or other *professionals* of the *effectiveness* and *efficiency* of services ordered or performed by other practicing physicians or other members of the profession whose work is being reviewed (peers).

penetration: in marketing *insurance* or *HMOs*, the percentage of possible *subscribers* who have in fact contracted for *benefits* (subscribed). *Participation* is sometimes used synonymously (see also *saturation*).

personal health services: all those health services provided to specific individuals. Contrasted with environmental and community health, *public health*, *consultation and education services* and health education, which are all usually directed at populations, not individuals, and are undertaken to promote healthful

environments, behavior and lifestyles.

policy: a course of action adopted and pursued by a government, party, statesman, or other individual or organization; any course of action adopted as proper, advantageous or expedient. Government makes policy principally by writing legislation and conducting oversight activities. The term is sometimes used less actively, to describe any stated position on matters at issue, i.e. an organization's policy statement on *national health insurance*. In *insurance*, a written contract of insurance between an *insurer* and the *insured*. In the executive branch of the Federal government of the United States, policies are documents which interpret or enlarge upon *rules*, and are sometimes referred to as guidelines. Policies bear the same relationship to rules (regulations) as rules do to law, except that, unlike regulations, they do not have the force of law.

pre-existing condition: an *injury* occurring, *disease* contracted, or physical condition which existed prior to the issuance of a health insurance policy. Usually results in an *exclusion* from coverage under the policy for costs resulting from the condition.

premium: the amount of money or consideration which is paid by an *insured* person or policyholder (or on his behalf) to an *insurer* or *third party* for insurance coverage under an *insurance policy*. The premium is generally paid in periodic amounts. It is related to the actuarial value of the *benefits* provided by the policy, plus a *loading* to cover administrative costs, *profit*, etc. Premium amounts for employment related insurance are often split between employers and employees (see *contributory insurance*); under current tax law, one-half of the amount spent on premiums by employees up to a maximum of \$150 is deductible for income tax purposes for those who itemize deductions. Premiums paid by the employer are non-taxable *income* for the employee. Premiums are paid for coverage whether benefits are actually used or not; they should not be confused with *cost-sharing*, like *copayments* and *deductibles* which are paid only if benefits are actually used.

prepaid group practice: an arrangement where a formal association of three or more physicians provides a defined set of services to persons over a specified time period in return for a fixed periodic *prepayment* made in advance of the use of service (see also *medical foundation* and *health maintenance organization*).

prepaid health plan (PHP): generically, a contract between an *insurer* and a *subscriber* or group of subscribers whereby the PHP provides a specified set of health *benefits* in return for a periodic *premium*.

prepayment: inconsistently used, sometimes synonymous with *insurance*, sometimes refers to any payment ahead of time to a *provider* for anticipated *services* (such as an expectant mother paying advance for maternity care), sometimes distinguished from insurance as referring to payment organizations (such as *HMOs*, *prepaid group*

practices and *medical foundations*) which, unlike an insurance company, take responsibility for arranging for and providing needed services as well as paying for them.

prevailing charge: a *charge* which falls within the range of charges most frequently used in a *locality* for a particular medical *service* or procedure. The top of this range establishes an over-all limitation on the charges which a *carrier*, which considers prevailing charges in reimbursement, will accept as *reasonable* for a given service, without adequate special justification.

prior authorization: requirement imposed by a *third party*, under some systems of *utilization review*, that a *provider* must justify before a *peer review* committee, insurance company representative, or State agent the *need* for delivering a particular *service* to a *patient* before actually providing the service in order to receive reimbursement. Generally, prior authorization is required for non-emergency services which are expensive (involving a hospital stay, *preadmission certification*, for example) or particularly likely to be overused or *abused*.

private practice: medical *practice* in which the practitioner and his practice are independent of any external *policy* control. It usually requires that the practitioner be self-employed, except when he is salaried by a partnership in which he is a partner with similar practitioners. It is sometimes wrongly used synonymously with either *fee-for-service* practice (the practitioner may sell his services by another method; i.e. *capitation*); or *solo practice* (*group practice* may be private). Note that physicians practice in many different settings and there is no agreement as to which of these does or does not constitute private practice. *Regulation*, which does exert external control, is not generally felt to make all practice public. The opposite of private practice is not necessarily public, in the sense of employment by the government. Practitioners salaried by private *hospitals* are not usually thought to be in private practice. (The professional staff thought this a difficult concept to define but the 13-year-old son of a physician got it started, saying, "That's easy. Practice of your own, charging what you want.")

professional liability: obligation of *providers* or their professional liability *insurers* to pay for damages resulting from the providers' acts of omission or commission in *treating patients*. The term is sometimes preferred by providers to medical *malpractice* because it does not necessarily imply negligence. It is also a term which more adequately describes the obligations of all types of *professionals*, e.g. lawyers, architects and other health providers, as well as physicians.

Professional Standards Review Organization (PSRO): A physician-sponsored organization charged with comprehensive and on-going review of *services* provided under the *Medicare*, *Medicaid* and *Maternal and Child Health* programs in the United States. The purpose of this review is to determine for purposes of reimbursement under these programs whether services

are: medically *necessary*; provided in accordance with professional *criteria, norms and standards*; and, in the case of institutional services, rendered in an *appropriate* setting. PSRO areas have been designated throughout the country and organizations in many of these areas are at various stages of implementing the required review functions (see also *peer* and *medical review*).

profit: the gain made by the sale of a good or service after deducting the value of labor, materials, rents, interest on *capital* and other expenses involved in the production of the good or service. Economists define profit as return to (or on) capital investment, and distinguish normal (competitive) and excessive (more than competitive) profit. Profit in the sense of a profit-making or *proprietary* institution is present when any of the net earnings of the institution inure to the benefit of any individual. The concept of profit is very hard to define operationally or in detail, and unreasonable or excessive profit even more so. It is important to recognize that reasonable profit on investments must vary with the risks involved in the investment. Profit bears a close relationship to the balance of *supply and demand*, being a measure of unmet demand.

proprietary hospital: a *hospital* operated for the purpose of making a *profit* for its owners. Proprietary hospitals are often owned by *physicians* for the care of their own and other *patients*. There is also a growing number of investor-owned hospitals, usually operated by a parent corporation which operates a chain of such hospitals.

prospective reimbursement: any method of paying *hospitals* or health programs in which amounts or rates of payment are established in advance for the coming year and the programs are paid these amounts regardless of the costs they actually incur. These systems of reimbursement are designed to introduce a degree of constraint on *charge* or *cost* increases by setting limits on amounts paid during a future period. In some cases, such systems provide incentives for improved *efficiency* by sharing savings with institutions that perform at lower than anticipated costs. Prospective reimbursement contrasts with the method of payment presently used under *Medicare* and *Medicaid* where institutions are reimbursed for actual expenses incurred (i.e. on a *retrospective* basis).

quality assurance: activities and programs intended to assure the *quality* of care in a defined medical setting or program. Such programs must include educational or other components intended to remedy identified deficiencies in quality, as well as the components necessary to identify such deficiencies (such as *peer* or *utilization review* components) and assess the program's own *effectiveness*. A program which identifies quality deficiencies and responds only with negative sanctions, such as denial of reimbursement, is not usually considered as a quality assurance program, although the latter may include use of such sanctions. Such programs are required of *HMOs* and other health programs assisted under authority of the *PHS Act* in the United States.

rating: in *insurance*, the process of determining rates, or the cost of insurance, for individuals, *groups* or classes of *risks*.

reasonable charge: for any specific *service* covered under *Medicare*, the lower of the *customary charge* by a particular *physician* for that service and the *prevailing charge* by physicians in the geographic area for that service. Reimbursement is based on the lower of the *reasonable* and *actual charges*. For example, suppose the prevailing charge for a fistulectomy is \$100 in a certain *locality*, i.e., this is the 75th percentile of the customary charges for that service by the physicians in that locality. Dr. A's actual charge is \$75, although he customarily charges \$80 for the procedure; Dr. B's actual charge is his customary charge of \$85; Dr. C's is his customary charge of \$125; Dr. D's is \$100, although he customarily charges \$80; and there are no special circumstances in any case. The reasonable charge for Dr. B would be \$85, because his customary charge is lower than the prevailing charge for that locality. The reasonable charge for Dr. C would be \$100, the prevailing charge for his locality. The reasonable charge for Dr. D would be \$80, because that is his customary charge which is lower than the actual charge in this particular case. His reasonable charge cannot exceed his customary charge in the absence of special circumstances, even though his actual charge of \$100 is the same as the prevailing charge. Generically, the term is used for any charge payable by an *insurance* program which is determined in a similar, but not necessarily identical fashion.

referral: the practice of sending a *patient* to another practitioner or to another program for *services* or *consultation* which the referring source is not prepared or qualified to provide. In contrast to referral for consultation, referral for services involves a delegation of responsibility for patient care to another practitioner or program, and the referring source may or may not follow-up to ensure that services are received.

registration: the process by which qualified individuals are listed on an official roster maintained by a governmental or non-governmental agency. Standards for registration may include such things as successful completion of a written examination given by the *registry*, membership in the *professional* association maintaining the registry, and education and experience such as graduation from an approved program or equivalent experience. Registration is a form of *credentialing*, similar to *certification*. Registration is also used to describe the recording of *notifiable diseases*, or the listing and follow-up of *patients* with such diseases.

regulation: the intervention of government in the health care or health *insurance* market to control entry into or change the behavior of participants in that marketplace through specification of rules for the participants. This does not usually include programs which seek to change behavior through financing mechanisms or incentives. It also does not include private *accreditation* programs

although they may be relied upon by government regulatory programs, as is the *Joint Commission on Accreditation of Hospitals* under *Medicare* in the United States. Regulatory programs can be described in terms of their purpose (control *charges*), who is regulated (*hospitals*), who regulates (State government), and method (prospective rate review). Regulatory programs include some *certification*, some *registration*, *licensure*, *certificate of need*, and *PSRO* and other programs. Also, a synonym for a *rule* published by the executive branch of the United States Federal government implementing the law.

reimbursement: payment by the scheme to the provider of health care, or to the protected persons as a refund, for all or part of fees for health services.

reinsurance: the practice of one insurance company buying *insurance* from a second company for the purpose of protecting itself against part or all of the *losses* it might incur in the process of honoring the *claims* of its policyholders. The original company is called the ceding company; the second is the assuming company or reinsurer. Reinsurance may be sought by the ceding company for several reasons: to protect itself against losses in individual cases beyond a certain amount, where competition requires it to offer policies providing coverage in excess of these amounts; to offer protection against catastrophic losses in a certain line of insurance, such as aviation accident or polio insurance; or to protect against mistakes in *rating* and *underwriting* in entering a new line of insurance such as *major medical*.

relative value scale or schedule (RVS): a coded listing of *physician* or other *professional services* using units which indicate the relative value of the various services they perform: taking into account the time, skill and overhead cost required for each service; but not usually considering the relative cost-effectiveness of the services, the relative *need* or *demand* for them, or their importance to people's *health*. The units in this scale are based on median *charges* by physicians. Appropriate conversion factors are used to translate the abstract units in the scale to dollar fees for each service. Given individual and local variations in *practice*, the relative value scale can be used voluntarily as a guide to physicians in establishing *fees for services*, and as a guide for insurance *carriers* and government agencies in determining appropriate reimbursement (e.g. use of relative value scales under *Medicare* where there is no *customary* or *prevailing charge* for covered service). An example is the scale prepared and revised periodically by the California Medical Association which includes independent scales for medicine, anesthesia, surgery, radiology and pathology. Relative value scales can contain biases favoring certain specialties (such as surgery) or types of services (highly technical or specialized) over others.

reserves: balance sheet accounts set up to report the *liabilities* faced by an insurance company under outstanding *insurance policies*. Their purpose is to secure

as true a picture as possible of the financial condition of the organization (by permitting conversion of disbursements from a paid to an accrual basis). The company sets the amount of reserves in accord with its own estimates, State laws, and recommendations of supervisory officials and national organizations. Regulatory agencies can accept the reserves or refuse them as inadequate or excessive. For *Blue Cross plans* in the United States, for example, reserves set aside to cover average monthly *claims* and operating expenses for some period of time. Reserves, while estimated, all are obligated amounts and have four principal components: reserves for known liabilities not yet paid; reserves for losses incurred but unreported; reserves for future benefits; and other reserves for various special purposes, including *contingency reserves* for unforeseen circumstances.

retrospective reimbursement: payment to *providers* by a *third party carrier* for *costs* or *charges* actually incurred by *subscribers* in a previous time period. This is the method of payment used under *Medicare* and *Medicaid* in the United States.

rider: a legal document which modifies the protection of an *insurance policy*, either expanding or decreasing its *benefits*, or adding or *excluding* certain conditions from the policy's coverage.

risk: generally, any chance of *loss*. In *insurance*, designates the individual or property *insured* by an *insurance policy* against loss from some *peril* or *hazard*. Also used to refer to the probability that the loss will occur.

risk charge: the fraction of a *premium* which goes to generate or replenish *surpluses* which a *carrier* must develop to protect against the possibility of excessive *losses* under its policies. *Profits*, if any, on the sale of insurance are also taken from the surpluses developed using risk charges. The risk charge is sometimes referred to as the retention or retention rate.

risk rating: adjusting of individual risk by insurer, usually based on age, pre-existing morbidity.

roster: a list of *patients* served by a given health *professional* or program (whose roster it is). The roster may be derived from a *registry* or list of *encounters* but the listing of an individual on a roster does not necessarily imply any ongoing relationship between the program and the individual (see also *catchment area*).

saturation: in marketing *insurance* or *HMOs*, the point at which further *penetration* is improbable or excessively costly.

scope of services: the number, type and intensity or complexity of *services* provided by a *hospital* or health program. Scope of services is measured, in a number of quite different ways, so that the capacity and nature of different programs may be compared. A program's scope of services should reflect, and be adequate to meet, the *needs* of its *patient mix*.

service benefits: those received as a result of *prepayment*

or *insurance*, whereby payment is made directly to the *provider of services* or the hospital or other medical care programs for covered services provided by them to eligible persons. Service benefits may be full service benefits, meaning that the plan fully reimburses the hospital, for example, for all services provided during a period so that the patient has no *out-of-pocket* expenses. Full service benefits may also be available when the program itself provides the service as in a *prepaid group practice*. Partial service benefits cover only part of the expenses, the remainder to be paid by the beneficiary through some form of *cost-sharing* (see also *vendor payment*).

shared services: the coordinated, or otherwise explicitly agreed upon, sharing of responsibility for provision of medical or non-medical *services* on the part of two or more otherwise independent hospitals or other health programs. The sharing of medical services might include, for example, an agreement that one hospital provide all pediatric care needed in a community and no obstetrical services while another undertook the reverse. Examples of shared non-medical services would include joint laundry and dietary services for two or more nursing homes. Common laundry services purchased by two or more health programs from one independent retailer of laundry services are not usually thought of as shared services unless the health programs own or otherwise control the retailer.

skimming: the practice in health programs paid on a *prepayment* or *capitation* basis, and in health insurance, of seeking to *enroll* only the healthiest people as a way of controlling program *costs* (since income is constant whether or not services are actually used). Contrast with *adverse selection*. Sometimes known as creaming. See also *skimping*.

skimping: the practice in health programs paid on a *prepayment* or *capitation* basis of denying or delaying the provision of services *needed* or *demanded* by *enrolled members* as a way of controlling costs (since income is constant whether or not services are actually used). The classic example is the denial or delay of a cataract extraction. See also *skimming* and *adverse selection*.

sliding scale deductible: a *deductible* which is not set at a fixed amount but rather varies according to *income*. A family is usually required to spend all (a *spend-down*) of a set percentage of their income above some base amount (for example, all or 25 percent of any income over \$5,000) as deductible before a member can receive medical care benefits. There may be a maximum amount on the deductible. The sliding scale concept can also be applied to *coinsurance* and *copayments*.

socialized medicine: a medical care system where the organization and provision of medical care *services* are under direct government control, and *providers* are employed by or contract for the provision of services directly with the government; also a term used more generally, without recognized or constant definition, referring to any existing or proposed medical care system believed to be

subject to excessive governmental control.

sponsored malpractice insurance: a *malpractice insurance* plan which involves an agreement by a *professional society* (such as State medical society) to sponsor a particular *insurer's* medical *malpractice* insurance coverage, and to cooperate with the insurer in the *administration* of the coverage. The cooperation may include participation in marketing, claims review, and review of ratemaking. Until 1975, this was the predominant approach to coverage in the United States. In 1975, a number of *carriers* with such arrangements announced they were withdrawing from them. They have been replaced by professional society operated plans, *joint underwriting associations*, State insurance funds and other arrangements.

standards: generally, a measure set by competent authority as the rule for measuring quantity or *quality*. Conformity with standards is usually a condition of *licensure*, *accreditation*, or payment for *services*. Standards may be defined in relation to: the actual or predicted effects of care; the performance or credentials of *professional* personnel; and the physical plant, governance and *administration* of *facilities* and programs. In the *PSRO* program in the United States, standards are professionally developed expressions of the range of acceptable variation from a *norm* or *criterion*. Thus, the criteria for care of a urinary tract infection might be a urinalysis in 100 percent of the cases and a urine culture only in previously untreated cases.

stock insurance company: a company owned and controlled by stockholders and operated for the purpose of making a *profit*, and contrasted with a *mutual insurance company*. In the former the profits go to the owners, in the latter they go to the *insured*.

subrogation: a provision of an *insurance policy* which requires an *insured* individual to turn over any rights he may have to recover damage from another party to the *insurer*, to the extent to which he has been reimbursed by the insurer. Some experts have argued that private health insurance (including *Blue Cross* or *group insurance*) should have subrogation rights similar to those in most property insurance policies (e.g. auto and fire). Having paid the *hospital bill* of a policyholder, the health insurance company could assume his right to sue the party whose negligence might have caused the hospitalization, and be reimbursed for its outlay to the policyholder. Subrogation rights could help insure prompt payment of medical expenses without *duplication of benefits*. Others respond that subrogation is time consuming, expensive and may not offer companies adequate protection against loss. Few insurers use it voluntarily and some *insurance commissioners* forbid its use.

subscriber: often used synonymously with either *member* or *beneficiary* but in a strict sense means only the individual (*family head* or employee) who has elected to contract for, or participate in (subscribe to) an *insurance* or *HMO* plan

for either himself and his eligible *dependents*.

substitution: the filling of a *prescription* by a *pharmacist* with a *drug* product *therapeutically* and *chemically* equivalent to, but not, the one prescribed. Many States have *anti-substitution laws* which prohibit the pharmacist from filling a prescription with any product other than the specific product of the manufacturer whose *brand name* is used on the prescription.

supplemental health insurance: health insurance which covers medical expenses not covered by separate health insurance already held by the *insured* (e.g. which supplements another insurance policy). For example, many insurance companies sell insurance to people covered under *Medicare* which covers either the costs of *cost-sharing* required by Medicare, services not covered, or both. Where *cost-sharing* is intended to control *utilization*, the availability of supplemental health insurance covering cost-sharing limits its effectiveness.

supplier: generally, any institution, individual or agency that furnishes a medical item or *service*. In *Medicare* in the United States, suppliers are distinguished from *providers*, including *hospitals*, and *skilled nursing facilities*. Institutions classified as providers are reimbursed by *intermediaries* on a *reasonable cost* basis while suppliers, including *physicians*, nonhospital laboratories and ambulance companies, are paid by *carriers* on the basis of *reasonable charges*.

supply: in health economics, the quantity of *services* supplied as the price of the service varies, *income* and other factors being held constant. For most services, increases in price induce increases in supply, and for all they ration existing supply. Increase in *demand* (but not, necessarily, in *need*) normally induce an increase in price.

surplus: in insurance, the excess of a company's assets (including any *capital*) over *liabilities*. Surpluses may be used for future dividends, expansion of business, or to meet possible unfavorable future developments. Surpluses may be developed and increased intentionally by including an amount in the *premium* in excess of the pure premium needed to meet anticipated liabilities known as a *risk charge*. Surpluses are sometimes earmarked in part as *contingency reserves* and in part as unassigned surplus.

third-party payer: any organization, public or private, that pays or *insures* health or medical expenses on behalf of *beneficiaries* or recipients (e.g. *Blue Cross* and *Blue Shield*, commercial insurance companies, *Medicare* and *Medicaid*). The individual generally pays a *premium* for such coverage in all private and some public programs. The organization then pays bills on his behalf; such payments are called third party payments and are distinguished by the separation between the individual receiving the *service* (the first party), the individual or institution providing it (the second party) and the organization paying for it (the third party). See also *service* and *indemnity benefits*.

trust funds: funds collected and used by the Federal government for carrying out specific purposes and

programs according to terms of a trust agreement or statute, such as the social security and unemployment trust funds. Trust funds are administered by the government in a *fiduciary* capacity for those benefited and are not available for the general purposes of the government. Trust fund receipts whose use is not anticipated in the immediate future are generally invested in interest bearing government securities and earn interest for the trust fund. The *Medicare* program in the United States is financed through two trust funds—the Federal Hospital Insurance Fund with finances Part A, and the Federal Supplementary Medical Insurance Trust Fund which finances part B.

underwriting: in insurance, the process of selecting, classifying, evaluating and assuming *risks* according to their *insurability*. Its fundamental purpose is to make sure that the group insured has the same probability of *loss* and probable amount of loss, within reasonable limits, as the universe on which *premium* rates were based. Since premium rates are based on an expectation of loss, the underwriting process must classify risks into classes with about the same expectation of loss.

underwriting profit: that portion of the earnings of an insurance company that comes from the function of *underwriting*. It excludes earnings from investments (other than interest earnings required by law or regulation to be assumed to have been earned for purposes of determining the *reserves* held) either in the form of income from securities or sale of securities at a *profit*. The remainder is found by deducting incurred *losses* and expenses from earned *premium*.

uniform cost accounting: the use of a common set of accounting definitions, procedures, terms, and methods for the accumulation and communication of quantitative data relating to the financial activities of several enterprises. The American Hospital Association, for example, encourages the use of its Chart of Accounts as a system which can be employed by *hospitals* in the United States.

universal coverage: coverage of all the citizens of a country by the scheme.

user charges: payments which a person has to make at the time of use of health services, in addition to the regular contributions to the scheme paid for by the insured person. Generally, these charges cover only part of the cost of services, and may take the form of a *circumvention fee*, *coinsurance*, or *copayment*.

utilization review (UR): evaluation of the *necessity*, *appropriateness* and *efficiency* of the use of medical services, procedures and facilities. In a hospital this includes review of the appropriateness of *admissions*, services ordered and provided, *length of stay*, and discharge practices, both on a concurrent and retrospective basis. Utilization review can be done by a *utilization review committee*, *PSRO*, *peer review group*, or *public agency* (See also *medical review*).

vendor: a *provider*, an institution, agency, organization or individual practitioner who provides health or medical services. *Vendor payments* are those payments which go directly to such institutions or providers from a *third party* program like *Medicaid*.

vendor payment: used in public assistance programs to distinguish those payments made directly to *vendors* of service from those cash income payments made directly to assistance recipients. The vendors, or providers of health services, are reimbursed directly by the program for services they provide to eligible recipients. Vendor payments are essentially the same as *service benefits* provided under health *insurance* and *prepayment* plans.

voluntary health agency: any *non-profit*, non-governmental agency, governed by lay and/or *professional* individuals, organized on a national, State, or local basis, whose primary purpose is health related. The term usually designates agencies supported primarily by voluntary contributions from the public at large, and engaged in a program of service, education, and research related to a particular *disease*, *disability*, or group of diseases and disabilities; for example, the American Heart Association, American Cancer Society, National Tuberculosis Association, and their State and local affiliates. The term can also be applied to such agencies such as non-profit *hospitals*, *visiting nurse associations*, and other local service organizations which have both voluntary contributions, and charges and fees for services provided.

voluntary health insurance: a health insurance program in which affiliation to the scheme is not determined by legislation.

waiting period: a period of time an individual must wait either to become eligible for *insurance* coverage, or to

become eligible for a given *benefit* after overall coverage has commenced (see *exclusions*). This does not generally refer to the amount of time it takes to process an application for insurance, but rather is a defined period before benefits become payable. Some policies will not pay *maternity benefits*, for example, until nine months after the policy has been in force. Another common waiting period occurs in *group insurance* offered through a place of employment where coverage may not start until an employee has been with a firm over 30 days. For disabled persons to be covered under *Medicare* in the United States, there is a waiting period of two years; a person must be entitled to social security *disability* benefits for two years before medical benefits start.

waiver of premium: a provision included in some policies which exempts the *insured* from paying *premiums* while he is *disabled* during the life of the contract.

warranty: in *malpractice*, actions against *physicians* are normally based on negligence, but in certain circumstances the plaintiff can bring his action on the basis of a warranty. A warranty arises if the physician promises or seems to promise that the medical procedure to be used is *safe* or will be *effective*. One of the advantages to bringing an action on warranty grounds, rather than for negligence, is that the statute of limitations is usually longer. A warranty action may be brought and maintained if there is an express warranty offered by the physician to the *patient*.

working capital: the sum of an institution's investment in short-term or current assets including cash, marketable (short-term) securities, accounts receivable, and inventories. Net working *capital* is defined as the excess of total current assets over total current liabilities.



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